FAMILY MEDICINE OF STARK COUNTY **PATIENT INFORMATION**

(Please complete front and back of form)

Name of Patient: _____

Address: _____City_____State_____Zip _____

Birth Date of Patient: _____ Gender of Patient: ____M____F

Social Security Number of Patient: _____ (Must have for lab purposes)

List any allergies to medications or products in regards to the Patient: _____

Guardian Name (if patient under 18): _____Phone: _____

Place of Employment_____ Employer Phone: _____

Patient Home Phone No.: _____ Patient Cell Phone No: _____

Patient email address: _____

Name of person we can contact in case of emergency: _____

Phone number of emergency contact person: _____

_ _

Please list names of people we are authorized to release information to: (**We only need full names, NOT phone numbers**.) The name must be listed below even if previously listed as emergency contact.

1. _____ 2. _____

3. _____ 4. _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

If you have any questions regarding this notice or our health information privacy policies, please contact our office manager at 330-499-5600.

I hereby acknowledge that I have been presented with a copy of Family Medicine, Inc's. notice or privacy practices.

Signature of Patient or guardian: _____ Date: _____

Print Name of Patient: _____