

Rhode Island Medicine, Inc.
Patient Information

Name _____ Date of Birth _____ Age _____

Social Security Number _____ Tel(home) _____ (work/cell) _____

Address _____
Street _____

City _____ State _____ Zip _____

Do we have permission to release any of your medical information to any friend or relative? _____ If yes, please list below:

Name _____ Relationship _____

Name _____ Relationship _____

Emergency Contact:

Name _____ Relationship _____ Telephone _____

Primary Insurance

Insurance Company _____ Membership No. _____

Person Responsible for account _____

Relation to patient _____ Soc Sec No. _____ Tel _____

Address _____

Employer Name and Address _____

Secondary Insurance

Insurance Company _____ Membership No. _____

Person Responsible for account _____

Relation to patient _____ Soc Sec No. _____ Tel _____

Address _____

Employer Name and Address _____

I have read and understand your 'Notice of Privacy Policy'.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I give Rhode Island Medicine, Inc. permission to use my protected health information for purposes of treatment, payment and health care operations. I am free to revoke this authorization at any time in writing.

Signature _____

Date _____