**RAYMOND ALDRIDGE, M.D., P.C.**
**PATIENT INFORMATION**

| | | | |
|---|---|---|---|
| **Patient** | | | |
| **Mailing Address**<br>City State Zip | | | **Phone**<br>Home<br>Work<br>Cell or Alternate |
| **Date of birth** | **Age** | **Gender** | **Social Security #** |
| **Patient employer** | | | |
| **Employer Address** | | | **Employer Phone** |
| **Spouse or Emergency contact** | **Spouse Birthday** | | **Spouse Phone** |
| **Spouse employer** | | | **Spouse Employer phone** |

**INSURANCE INFORMATION**

| **Primary Insurance** | **Secondary Insurance** |
|---|---|
| | |

**Primary physician**

**Referring**

**Pharmacy**

**HIPPA INFORMATION**

May we release information about you to your spouse? ☐ Yes ☐ No
If yes, your spouse's name _____ If at any time you no longer want your spouse to receive any of your information you need to contact us in writing as soon as possible.

**Please list any other person that we can release your information to:**
**PLEASE CIRCLE RELATIONSHIP**

| | | | | |
|---|---|---|---|---|
| | Relationship: Son/daughter | Brother/sister | Relative | Friend |
| | Relationship: Son/daughter | Brother/sister | Relative | Friend |
| | Relationship: Son/daughter | Brother/sister | Relative | Friend |

**CONSENT TO TREAT**

I give permission to the physician and whomever he may designate as his assistant(s) to administer such treatment as is necessary, and to perform any medical care, procedure or testing that is considered therapeutically necessary based on findings during my examination or treatment.

**CONSENT FOR HIPAA, RELEASE OF INFORMATION, AND PAYMENT**

I hereby authorize Dr. Raymond Aldridge and/or his Associates to release any protected health information pertaining to the examination, treatment, history, prescribed medications, and medical expenses of myself to any physician, hospital, Medicare, Medicaid, Tricare, Insurance Company and all other agencies deemed necessary. I understand that I have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent. I also authorize payment of medical benefits to Dr. Raymond Aldridge for services rendered. I understand that I am financially responsible for any co-pays, co-insurance, or deductibles required by my insurance company. I also understand that I am financially responsible for charges that are not covered by my insurance company.

**Signature of patient or authorized person** _____

**Date** _____