CONFIDENTIAL PATIENT INFORMATION

Date _____

Name: _____ Home Phone: _____

Address: _____ Social Security No.: _____

City: _____ State: Zip _____ Drivers License No.: _____

Age: _____ Birth date: ___/___/___ How many children: _____ Marital Status: S M Other Sex M F

Occupation: _____ Email: _____ Employer: _____

Address: _____ Office Phone: _____

Name of Spouse: _____ DOB: _____ Occupation: _____

Employer: _____ Office Phone: _____

Patients Nearest Relative: _____ Phone: _____

Referred By: _____ Date of Last Physical Exam: _____

Have you ever suffered from

1. Dizziness	☐ Yes ☐ No		8. Asthma/Respiratory Disorders	☐ Yes ☐ No	
2. Backaches	☐ Yes ☐ No		9. Neurological Disorders	☐ Yes ☐ No	
3. Heart Trouble	☐ Yes ☐ No		10. Digestive Disorders	☐ Yes ☐ No	
4. Diabetes	☐ Yes ☐ No		11. Nervousness/Anxiety	☐ Yes ☐ No	
5. Tuberculosis	☐ Yes ☐ No		12. Sinus Trouble	☐ Yes ☐ No	
6. Arthritis	☐ Yes ☐ No		13. Anemia/Blood Disorders	☐ Yes ☐ No	
7. Headaches	☐ Yes ☐ No		14. Cancer	☐ Yes ☐ No	

Purpose of Appointment: _____

Other Doctors seen for this Condition: _____

Have you been treated for any health condition by a physician in the past year? ☐ Yes ☐ No

Describe: _____

Remarks and additional information: _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment: _____

Are you insured? ☐ Yes ☐ No Company: _____ Phone: _____

ASSIGNMENT AND RELEASE:
I hereby authorize my insurance benefits to be paid directly to the doctor and I am financially responsible for services that are not covered. I also authorize the doctor to release any information required to process this claim.

Patient's Signature _____ Date: _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that _____ will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to _____ will be credited to my account on receiept. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due immediately.

Patient's Signature _____ Date: _____

Guardian or Spouse's Signature _____ Date: _____

Information Taken By _____ Date: _____

Abundant Life Naprapathic Medicine of New Mexico

Dr. Patrick Nuzzo, DN

Dr. of Naprapathy

3600 Cerrillos Road, Suite 407

Santa Fe, NM 87507

(505)424-8990
(505)424-6377

drpatricknuzzo@sbcglobal.net

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83-0429485

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PATIENTS ACKNOWLEDGEMENT OF RECEIPT OF HIPPA PRIVACY RULES

I, _____, have received a copy of the Notice of HIPPA Privacy Practices of the office of _____.

Opting Out:

_____ I do not want appointment reminder messages left on my home answering machine. I understand that the office may charge me should I fail to keep my appointment

_____ I want appointment reminder messages left on my home answering machine. I understand that the office may charge me should I fail to keep my appointment

_____ I do not want appointment reminder messages left on my office voice mail system. I understand that the office may charge me should I fail to keep my appointment

_____ I want appointment reminder messages left on my office voice mail. I understand that the office may charge me should I fail to keep my appointment

_____ I wish my protected health care information to be released to the following person(s)

_____ I do not wish my protected health care information to be released to the following person(s)

Name _____

Address _____

Please print your name_____

Please sign and date _____

_____ I decline to sign the Acknowledgement

Office Use:
The office was unable to obtain a signed Acknowledgement form from the above patient for the following reasons:

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