BARRY J. EDISON, D.O., PC
Patient Information

PLEASE PRINT CLEARLY

Patient Name: _____
Last Name First Name Middle Initial

Patient Birthdate_____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Social Security #: _____- _____-_____ Marital Status: S M D W Other

Address:_____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ ☐ Check if preferred method of contact

Work Phone#: (_____) _____ ☐ Check if preferred method of contact

Cell Phone #: (_____) _____ ☐ Check if preferred method of contact

Email Address: _____

Emergency Contact Name: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

HIPAA STATEMENT:

I have read and agree with Barry J. Edison, D.O., PC **HIPAA Notice of Privacy Policy**. I hereby authorize Barry J. Edison, D.O., PC to furnish to my insurance company or authorizing agency information regarding my protected health information for the purposes of treatment, payments, or health care operations. I further authorize the physician(s) Barry J. Edison, D.O., PC to consult as needed in their sole discretion with other medical providers regarding my medical care.

X:_____ **Date:** _____
Signature of Responsible Party