INFECTION PREVENTION & TREATMENT CENTER, LLC
Dr. Nathaniel Ratnasamy

Patient Full Name: ________________________________ Birthdate: _________ Age: ______
Last First MI

Address:__________________________City: ___________________ State:______ Zip:_______

SS#:________________________ Marital Status: S__ M __ W __ D __

Race: American Indian__ Asian__ Black or African American__ Black Hispanic or Latino__

Native Hawaiian or Other Pacific__ White__ White Hispanic or Latino__ Prefer not to answer__

Language Preference: English__ Chinese__ French__ German__ Italian__

Japanese__ Korean__ Portuguese__ Russian__ Spanish__ Prefer not to answer__

Home Phone #: ________________-ok to leave message Y/N

Cell Phone#: _________________-ok to leave message Y/N

Work Phone#: __________________ Ext:_____ - ok to call you at work Y/N

Which number do you prefer we call first: Home / Cell / Work (please circle **one**)

Email address: ______________________________@___________________

Emergency contact (a different # than above): _________ Relationship: _____ Phone: _____________

All insurance information must be completed for us to submit it for you.

INSURANCE INFORMATION- PRIMARY INSURANCE

Insurance Company Name: ________________ID # ___________________ Group # ______________
Name of person who carries the insurance and relationship to the patient: ________________________
Insured information needed to file the claim – Insured Birthdate:______ Insured SS# _______________

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _______________ ID # ___________________ Group # ______________
Name of person who carries the insurance and relationship to the patient: ________________________
Insured information needed to file the claim – Insured Birthdate:______ Insured SS# _______________

Please give us your insurance card or cards so we can make a copy for our records. Thank you.

Please complete both sides.

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Local Pharmacy (be specific): ______________________ City: ______________________

Please list the names of the people who we are allowed to speak with regarding your health information.

Spouse, Significant Other: ______________________ Children/Parent(s): ______________________

Other: ____

Please list the names of the physicians who are currently involved in your care and we will send them a copy of our office notes.

Family Physician: __________________ Specialists: ______________________________________

I authorize the release of any information regarding my medical condition or treatment to my insurance carrier (s) and to any third party account collection or administrators as may be necessary for billing and collection purposes. I further understand that I am responsible for all medical expenses and agree to pay any expenses not covered by my insurance.
By signing this authorization form, I am agreeing to the disclosure of my health information. I have received a copy of the HIPPA Notice of Privacy Practice and understand that it is also posted in the physician's office.
I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.
I have given an email address that can be used for communicating either an appointment reminder or to get a code to go check results on a third person health information server that is HIPPA compliant.
Also by signing this authorization I am giving consent for in office photography for medical treatment purposes and for verification of your identity.

Signature of Patient/Parent/Guardian/or POA	Date
______________________________	______________________
______________________________	______________________
______________________________	______________________
______________________________	______________________
______________________________	______________________