

**Hopkins Clinic for Physical Medicine**

**Confidential Patient Information**

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**PATIENT INFORMATION FORM**

**Welcome to Hopkins Clinic.** Help us help you by completing this form. Please answer all the questions completely. All information provided is strictly confidential. **If you do not understand a question or are unsure of the information, please ask for assistance.**

Name: (First)\_\_\_\_\_ (Middle) \_\_\_\_\_ (Last)\_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_ can we email you? Yes \_\_\_ No \_\_\_

Soc. Sec. # : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male / Female

Single / Married / Divorced / Separated Spouse Name \_\_\_\_\_

Your Occupation \_\_\_\_\_ Work phone #: (\_\_\_\_) \_\_\_\_\_ Can we call you there? Y or N

In emergency, contact \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Automobile Ins. Co. \_\_\_\_\_ Name of Primary policy holder: \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Date of Accident \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Name of Primary policy holder: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Name of Primary policy holder: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

I have read all the questions thoroughly and to the best of my knowledge and memory at this time, the information I have given is accurate and complete. If accepted as a patient, I hereby give the doctor permission to perform on myself (or minor child for whom I declare I am the parent or legal guardian) such general procedures as they may deem necessary in the diagnosis and/or treatment of my (their) condition

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices **Short Form**. I have had the opportunity to read the complete Notice of Privacy Practices or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient, Parent, Guardian or Patient’s legal representative signature