# Patient Information Sheet

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Is it ok to mail your health information (ie: test results) to this address? ☐ YES ☐ NO

**Your insurance requires you to let us know if your visit is accident related (i.e.: auto accident, workers compensation, etc.)

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM

1. Acknowledgement of Privacy Practice Notice: I have received a copy of The Office of Edred V. Shen, MD: Notice of Privacy Practices.

2. I wish to be contacted in the following manner:

Primary Phone Number: _____

**Please choose one only

- ☐ OK to leave a message with detailed information
- ☐ Leave message with Name and call back number only

Secondary Phone Number: _____

**Please choose one only

- ☐ OK to leave a message with detailed information
- ☐ Leave message with Name and call back number only

Work Phone Number: _____

**Please choose one only

- ☐ OK to leave a message with detailed information
- ☐ Leave message with Name and call back number only

Fax Number: _____

Is it ok to fax your health information (ie: test results) to this fax number? ☐ YES ☐ NO

Email Address: _____

I have filled out this form honestly to the best to my ability.

_____

Name (Please Print)

_____ _____

Signature of Patient/Parent/Guardian Date