PATIENT INFORMATION

Last Name | First Name | Middle Initial

Address | City | State | Zip Code

Home Phone | Cell Phone | Work Phone

Email

Date of Birth | Social Security Number | ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other

Race: ☐ Black ☐ American Indian ☐ White ☐ Asian/Pacific Islander ☐ Other Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Occupation | Employer | Employer Phone

RESPONSIBLE PARTY INFORMATION

Relationship to Patient ☐ Self (If Self, skip to Emergency Contact) ☐ Spouse ☐ Parent ☐ Other

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Address | City | State | Zip Code

Home Phone | Cell Phone | Work Phone

EMERGENCY CONTACT INFORMATION

Last Name | First Name | Relationship to Patient

Address | City | State | Zip Code

Home Phone | Cell Phone | Work Phone

MEDICAL RECORD RELEASE AUTHORIZATION (SPOUSE, FAMILY, ETC)

I, _____, authorize the representatives of PEMCARE, LLC to share and/or release my medical information to:

1)_____ Relationship _____

2) _____ Relationship _____

3) _____ Relationship _____

I understand that I have the right to change this authorization, in writing, at any time.

Signature _____ Date _____