Sanford M. Silverman, MD, PA

Comprehensive Pain Medicine
Spinal Diagnostics and Therapeutics

NAME ____
Last First Middle initial

LOCAL ADDRESS ____
Street City State Zip

PERMANENT ADDRESS ____
Street City State Zip

PHONE (____)_______________/ (_____)_______________ **SEX**: M F **MARITAL STATUS**
Home work S M D W

DATE OF BIRTH ____/____/____ AGE _____ SS#______________________________
Mo day year

EMERGENCY CONTACT; RELATIONSHIP AND PHONE______________________________

WHOM MAY WE THANK FOR REFERRING YOU?______________________________

INSURANCE CO. NAME ________________________ **POLICY#** ______________ **GROUP#** ____________

NAME & RELATIONSHIP OF INSURED ______________________________

SECONDARY INSURANCE ______________________ **POLICY#** ______________ **GROUP #** ___________

DRIVERS LICENSE #____________________________ **OCCUPATION** ____________________________

EMPLOYER NAME & PHONE ______________________________

TO WHOM MAY WE **DISCLOSE** YOUR PROTECTED HEALTH INFORMATION?

____

TO WHOM MAY WE **NOT DISCLOSE** YOUR PROTECTED HEALTH INFORMATION?

____

DATE OF INJURY:

SIGNATURE ON FILE: I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

____
Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my protected health information, or to request additional confidential treatment of communications between the Practice and myself or others.

____
Signature Date