

**MEDAC HEALTH SERVICES, P.A.**

4402 Shipyard Boulevard, Wilmington, NC 28403      910-791-0075  
 1442 Military Cutoff Road, Wilmington, NC 28403      910-256-6088  
 8115 Market Street, Wilmington, NC 28411      910-686-1972

**MEDAC CORPORATE HEALTH**

4402 Shipyard Boulevard, Wilmington, NC 28403      910-452-7000

Today's Date		<b>PATIENT INFORMATION</b> <i>This Form Must Be Completed Annually</i>				Method of Payment				
Patient Information	Last Name		First Name		Middle Name		Primary Phone			
	Street Address		Apt #	City		State	Zip			
	Permanent Address		Apt #	City		State	Zip			
	Social Security Number		Birth Date	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
	Employer		Address			Business Phone				
	Emergency Contact Name		Address			Primary Phone	Other Phone			
	E-mail Address			E-mail Address 2						
	Do you give permission for Medac to leave a medical message on your primary phone number or ask that you return a call to our office? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Responsible Party <small>if patient is younger than 18</small>	Last Name		First Name		Middle Name					
	Street Address		Apt #	City		State	Zip			
	Social Security Number		Birth Date	Relationship to Patient						
	Employer			Address			Business Phone			
Accident Information	If your condition is related to an accident:				Is the accident:					
	Date	Time	<input type="checkbox"/> am <input type="checkbox"/> pm		<input type="checkbox"/> auto related <input type="checkbox"/> work related					
	Specifics of accident									
Insurance Information	Primary Insurance				Secondary Insurance					
	Policy #		Group #		Policy #		Group #			
	Name of Policyholder				Name of Policyholder					
	Address of Policyholder		City	State	Zip	Address of Policyholder		City	State	Zip
	Policyholder Phone		Policyholder Birth Date		Policyholder Phone		Policyholder Birth Date			
	Social Security Number of Policyholder		Employer of Policyholder		Social Security Number of Policyholder		Employer of Policyholder			
	Relationship to Patient				Relationship to Patient					
HIPAA Authorization Acknowledgement and Consent	I acknowledge that I have received or been offered a copy of Medac's Notice of Information Practices (effective date April 14, 2003). I hereby authorize Medac to release to the below listed individuals, upon their request and without further authorization from me, information concerning treatments the above listed patient receives as a patient of Medac and copies of any and all medical records. This authorization is made at my request and will not expire unless revoked by me. I understand that I may revoke or restrict at any time the right of any of these individuals to receive this medical information by providing said revocation or restriction to Medac in writing. I understand that Medac will not condition treatment upon whether I authorize these individuals to receive this information. I understand that any health information and medical records disclosed to the below listed individuals may possibly be re-disclosed by them without any restrictions under federal or state privacy regulations.									
	Name				Name					
	Relationship				Relationship					