GRAMERCY PAIN MANAGEMENT
DEMOGRAPHICS & HIPPA ACKNOWLEDGEMENT

Today's Date: ______________________

Patient's Name: ______________________

Street Address: ____

City: ________________ State: ________ Zip: _______________

Home (primary) Phone: _______________

Cell Phone:________________________ Work Phone:______________________

Email: ______________________________ Permission to email __ Y __ N

Primary Care Physician: __________________ Phone: ______________________

Referring Physician: ___________________ Phone: ______________________

DOB: ________ Sex: ________________

Marital Status: S M W D

Social Security#____

Employer:____

Emergency Contact Name:____________________________________

Relationship:____

Phone:____

Pharmacy ____________________ City _______________________

GPM has permission to obtain my Rx History (NY Law). Please initial that you agree_______

Is your condition related to a work related injury? _____ A motor vehicle accident? ____

If you have Medicare is it primary? _______________________

Primary Insurance Holder: _____________ DOB:______________ ***(if different than patient)***

Signature below is acknowledgement that you have received the notice on our HIPPA/ Privacy Practices:

Print Name: _____________________________ Signature: ________________ Date:___________