Interventional Radiology, P.C.

PATIENT INFORMATION

Last Name: _____ First name: _____ Middle Initial: _____

Date of Birth: _____

Gender: F M

Address _____

Phone: _____ Cellular: _____

Email: _____

Employer: _____

Work Tel: _____

I give permission for Interventional Radiology, P.C. to contact me by the following methods (Please circle all that apply):

Email

Phone/cellular

Text

The healthcare providers and staff at Interventional Radiology, PC are trained in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure privacy, confidentiality, and security of patient information. If you would like to receive a copy of the Interventional Radiology, PCs HIPAA Privacy Notice please do so by requesting a copy from the receptionist.

Patient (Guardian) Signature: _____ Date _____

Patient (Guardian) Name (Please print): _____