ECM
ELITE
CONCIERGE
MEDICAL

Name: **Birthdate:** / /
DAY MONTH YEAR

Address:

City: **State:** **Zip:**

Cell Phone: **Can We Text Your Phone?** **Yes** **No**

Home Phone:

Email:

Employer: **Phone Number:**

Emergency Contact: **Phone Number:**

Primary Care Physician: **Phone Number:**

Medications:

Allergies:

Date of Last Imaging (X-Rays, MRI & CT Scan):

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HIPAA DISCLOSURE

Elite Concierge Medical agrees to follow all HIPAA regulations and protect the client's right to privacy, in compliance with the 1996 Congressional Act, to protect the privacy of patient's health information. Medical information is strictly in the use of the clinic's staff in the normal treatment protocol set forth by the program. All medical information is strictly confidential and contact with your physicians or specialist as deemed necessary for the program prescribed. No information will be sold or provided to any third party. All client information provided on this site is secured.

If at any time you feel your rights have been violated, contact Elite Concierge Medical directly.

Print Name: _____ **Date:** _____

Signature: _____

Witness: _____