

Annual Patient Update Packet

			PATIE	ENT INFO	RMATION				
Last Name	ame First			Name		Social Secu	Social Security #		
Address									
Home Telephone			Cell Phone	Cell Phone		Date of Birth Age			
Email :			up for	s! Sign me Genesis updates.	Consent to		No No	I	
Please Check	All That Ap	ply	,		1				
Gender:	Male Gender	Male Female Female-to-M					Male-to-Female/Transgender Female		
Sexual Orientation:		Bisexual Rather Not Dis	isexual Lesbian/Gay/		y/Homosexual Stra		ual	Unknown	
,QVXUHG¶V /DQ、		J X D J ∐n lglish	Spanish	Chinese	French	German	Italian	Sign Language	
								Korean	
	Pacific Is Samoan		ian Indian n or Chamorro	Chinese Rathe	Filipino r Not Answer	Japanese Other	Vietr	namese	
•	Hispanic/Lat Mexican Ame	ino Non-Hispa	anic/Latino	Mexican Co	uhan	eran Status:			

Rather Not Answer



NARCOTIC ACKNO	WLEDGMENT
I (Print Name)	acknowledge that it has been explained to me that
Genesis Healthcare, Inc. does not provide chronic narcotic pain management	ent. This includes the use of narcotic medication as well as othe
supplemental controlled substances. I understand and agree that I will be r	eferred to another clinic for pain management by that facility's
physician.	
Patient Signature/Patient Authorized Representative Date	
Relationship to Patient if patient unable to sign.	
ANSWERING MACHINE/VOIC	E MAIL MESSAGES
There may be times when our office is not able to reach you by tele	phone. With your permission, we would like to be able to
leave messages on your home answering machine/cell phone voice	mail. To comply with strict legal standards, a written
release will allow us to leave a message on your answering machin	
messages on your answering machine at the telephone number you	have given us in your record.
Patient/Patient Authorized Representative Signature:	
Patient Name (Print):	Date:
Relationship to patient if Unable to Sign:	
HIPAA AUTHORIZATION FOR RELEASE	OF MEDICAL INFORMATION
Some patients prefer other individuals, especially family members	s, be allowed access to their medical information. To
comply with strict legal standards, a written release is required to	•
This release grants permission to individual(s) listed below to: Ma	
laboratory findings, pick up sample medications, be made aware	
serve as your emergency contact. This permission applies to tele	phone and answering machine messages as well as
other means of communication.	Date
3DWLHQW¶V 6 <u>LJQDWXUH</u>	Date:
Patient Print:	
1. Designated Party:	

Telephone:

