The Mount Sinai Hospital New York, NY Outpatient Facesheet	Date:	Medical Record Number

Patient's Name			Gender	Race
Social Security Number	Age	Date of Birth	Marital Status	Ethincity
Patient's Address				Religion
Patient's Address Continued			Home Phone	Cell Phone
Patient's E-mail Address				

Emergency Contact	Relationship to Patient	Gender	Phone Number
Emergency Contact Address			

Insurance 1 Health Plan Name	Policy Number	Group Name	Group Number
Health Plan Type	Financial Class		
Health Plan Address		Health Plan Phone Number	
Subscriber Name	Relationship to Patient	Subscriber Date of Birth	
Subscriber Employer Name	Employment Status	Subscriber Home Phone	

Insurance 2 Health Plan Name	Policy Number	Group Name	Group Number
Health Plan Type			
Health Plan Address		Health Plan Phone Number	
Subscriber Name	Relationship to Patient	Subscriber Date of Birth	
Subscriber Employer Name	Employment Status	Subscriber Home Phone	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

Patient Signature: _____ Date: _____

- ☐ The patient refused to sign despite good faith efforts
- ☐ The patient was unaccompanied and not alert and oreinted
- ☐ The patient was unaccompanied and needed emergency care
- ☐ Other, (explain): _____

Employee Signature: Employee Title:

Print Name: Date: