**Patient Registratio n**

# Legal name:

**Birthday (MM/DD/YYYY): Preferred name:**

# Social security number:

**Would you like to sign up for the patient portal?**  Yes  No **Email**: **Mailing address:**

*Street Number Street Apt #/ P.O Box City/State/Zip Code*

**1st phone number 2nd phone number**

* home  work  cell
* home  work  cell

**Emergency Contact**

**Relationship**

**Phone number**

**Relationship:**  Single  Married  Partnered  Divorced  Separated  Widowed **Sexual orientation:**  Straight  Gay  Lesbian  Bisexual  Other  Decline **Sex assigned at birth:**  Female  Male

**Gender identity:**  Female  Male  Trans

Woman

* Trans

Man

* Nonbinary  Decline

**Employment:**  Fulltime  Parttime  Unemployed  Self-Employed

* + Retired  Disabled  Fulltime Student  Parttime Student

**Where I work/school: What I do for work/school:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Race:** | * American Indian/Alaska Native | * Asian | * Asian Pacific American |
|  | * Black or African American | * Caucasian/White | * Native American |
|  | * Subcontinent Asian American | * Pacific Islander | * Other |
|  | * Decline to answer |  |  |
| **Ethnicity:** | * Hispanic or Latino/a | * Not Hispanic or Latino/a | * Decline to answer |

**My preferred spoken language: My preferred written language:**

**Do you need an interpreter?**  Yes  No

I understand that I am voluntarily seeking medical treatment. I understand that I am authorizing treatment by East Paris Internal Medicine Associates, P.C. and that I am financially responsible for all charges for services rendered to me including the balance remaining after payment of possible insurance benefits. I authorize payment of medical expenses to the provider of professional services tendered. I understand that I may refuse specific treatments or procedures by informing my health care team.

**Signature of Patient: Date:**

**GENERAL CONSENT FOR TREATMENT (ALL PATIENTS)**

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in East Paris Internal Medicine Associates, P.C.. including physician services. I authorize any holder of medical or other information about me be released to the Centers for Medicare and Medicaid and its agents any information needed to determine these benefits or benefits for related services.

**Signature of Patient: Date:**

**CONSENT TO FOR MEDICARE AUTHORIZATION (MEDICARE ONLY)**

I acknowledge I have received (or have been offered) a copy of East Paris Internal Medicine Associates Notice of Privacy Practices that explains when, where, and why my protected health information may be used or shared by East Paris Internal Medicine Associates. I understand that I may request additional restrictions on the use and disclosure of my PHI or for additional confidential treatment of communications.

**Signature of Patient: Date:**

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

## AUTHORIZATION TO SHARE AND PERMITTED USE OF PROTECTED HEALTH INFORMATION (PHI)

**Purpose of request:** I authorize East Paris Internal Medicine Associates, PC to disclose or provide my protected health information to the following individual(s) listed below who are authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, they may exercise my right to inspect, copy, and request amendments to my protected health information. They may also consent or authorize the use or disclosure of my protected health information.

## Name Phone Number

**Name Phone Number**

## Name Phone Number

**□** I **do not** wish to share my PHI with anyone other than myself, except as permitted by HIPAA and as described in East Paris Internal Medicine Associates Notice of Privacy Practices

## Signature of Patient: Date: