# NEW PATIENT FORM

DATE ___________________ ACCOUNT # ________________

## PATIENT INFORMATION

Last Name ______________________________________

First Name ______________________________________

Address ______________________________________

City ____________________ State ______ Zip __________

Home Telephone ______________________________________

Cell Phone ______________________________________

Employer ______________________________________

Email ______________________________________

Date of Birth _____________________ Age ____________

Social Security # ______________________________________

Driver's License # ______________________________________

Emergency Contact ______________________________________

Telephone ______________________________________

Address ______________________________________

__________________________________ Apt. # ________

City ____________________ State ______ Zip __________

Who referred you to us? ______________________________

Race: ❑ American Indian ❑ Asian ❑ African-American ❑ Alaska Native
❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Other

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined

Sex: ❑ Male ❑ Female ❑ Transgender

## POLICY HOLDER INFORMATION (if patient is not policy holder relationship to policy holder ___________ )

Last Name ______________________________________

First Name ______________________________________

Address ______________________________________

City ____________________ State ______ Zip __________

Home Telephone ______________________________________

Spouse's Name ______________________________________

Social Security # ______________________________________

Employer ______________________________________

Cell Phone # ______________________________________

Message Phone # ______________________________________

Date of Birth ______________________________________

Driver's License # ______________________________________

## INSURANCE INFORMATION

Please enter information about the **POLICY HOLDER (if patient is not policy holder)**

Insurance Company ______________________________________

Group Number ______________________________________

Insurance ID # ______________________________________

Owner of the Policy ______________________________________

Insurance Company Address ______________________________
______________________________________________

Ins. Phone # ______________________________________

Employer ______________________________________

Relationship to Patient ______________________________

Is this a work related injury or motor vehicle injury? _________

**Managed Care Programs:** If I am or become a member of an affiliated managed care program, I understand that it is my responsibility to know the limits and benefits of my plan. If I accept health services that are found by my plan to be "non-covered", I agree to promptly pay the customary charges for these services.

**I hereby authorize the release of medical information to my insurance company(s), and assign benefits otherwise payable to me to Arlington Family Practice. A copy of this is as valid as the original. I understand that payment is due at the time of service, and I am totally responsible for my charges.**

Signature ______________________________________________ Date ____________________

(over)

## Consent to Treat

I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures and medical treatment by the physicians of **Arlington Family Practice**, their staff and designees, as may in their professional judgement, be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

____ Initial

## PHI Consent

I consent to the use or disclosure of my protected health information by **Arlington Family Practice** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Arlington Family Practice.**

____ Initial

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Arlington Family Practice** is not required to agree to the restrictions that I may request. However, if **Arlington Family Practice** agrees to a restriction that I request, the restriction is binding on **Arlington Family Practice** and the **physicians of Arlington Family Practice.**

____ Initial

I have the right to revoke this consent, in writing, at any time, except to the extent that the **physicians of Arlington Family Practice** or **Arlington Family Practice** has taken action in reliance on this consent.

____ Initial

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review **Arlington Family Practice's** Notice of Privacy Practices prior to signing this document. The **Arlington Family Practice's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Arlington Family Practice.** The Notice of Privacy Practices for **Arlington Family Practice** is also provided in the reception room of the Practice. This Notice of Privacy Practices also describes my rights and the **Arlington Family Practice's** duties with respect to my protected health information.

____ Initial

____ **I have been given** Arlington Family Practice Notice of Privacy Practices for review.

Initial

______________________________________ ______________________________________

**Signature of Patient of Personal Representative** **Date**

______________________________________ ______________________________________

**Name of Patient or Personal Representative** **Description of Personal Representative's Authority**

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Please list people with whom we can discuss your care and leave messages.

1)____________________________ Relationship to Pt ____________ Ph #_______________________

2)____________________________ Relationship to Pt ____________ Ph #_______________________

May we leave a message regarding your care on your answering machine? ( ) Yes ( ) No
May we leave a message regarding your care on your cell phone? ( ) Yes ( ) No
May we text you a message on your cell phone regarding your care? ( ) Yes ( ) No
(please understand that if we cannot leave messages, it will be your responsibility to initiate contact with us regarding follow-up of lab appointments, etc.)