PATIENT REGISTRATION ____NEW ____UPDATE

ORMOND INTERNAL MEDICINE, LLC (HEREINAFTER REFERRED TO AS OIM)

LAST NAME: _____ FIRST NAME: _____ MI: _____
PRIMARY ADDRESS: _____ APT/UNIT/LOT#: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE: _____ CELL PHONE: _____

- PRIMARY LANGUAGE: _____
- RACE: _____
- ETHNICITY: _____

DATE OF BIRTH: _____ SSN: _____
EMAIL ADDRESS: _____@_____.COM (THIS IS FOR USE BY OIM ONLY)

PLEASE CIRCLE ANSWERS AS APPLICABLE;

CONTACT PREFERENCE: HOME PHONE CELL PHONE EMAIL PORTAL
MARTIAL STATUS: SINGLE MARRIED DIVORCED LEGALLY SEPARATED WIDOWED
GENDER: Legal Sex _____ as it appears on your legal documents (D.L., Ins., etc)
Assigned Sex at Birth _____ as it appears on your birth certificate
Gender Identity (optional) _____ an individuals self-declared sense of being

EMERGENCY CONTACT:

1. NAME (PLEASE PRINT): _____RELATIONSHIP: _____
   HOME NUMBER: _____WORK/CELL NUMBER: _____
2. NAME (PLEASE PRINT): _____RELATIONSHIP: _____
   HOME NUMBER: _____WORK/CELL NUMBER: _____

___YES, I understand, as outlined in the HIPAA Notice of Patient Privacy Practices, my personal medical information may be made known, as it pertains to my medical treatment, payment of charges, or procedure of the practice. The practice is authorized to release my personal medical information to the individual(s) listed above.

___NO, I understand, as outlined in the HIPPA Notice of Patient Privacy Practices, and I **DO NOT** wish to have my information released to anyone other than medical professionals and insurance companies as it applies to me.

___ EMPLOYED ___FULL-TIME ___PART-TIME ___UNEMPLOYED ___STUDENT ___RETIRED
PROFESSION: _____ COMPANY NAME: _____
COMPANY PHONE NUMBER: __ (____) _____ ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

CONSENT FOR TREATMENT: This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment and services at OIM by the provider on duty. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at OIM. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedures.

____ Yes, I have been advised of the office's HIPPA Privacy policies and guidelines. I understand that I will be provided a copy of the policies and guidelines upon request.

SIGNATURE OF PATIENT: _____ DATE: _____

PRINTED NAME OF PATIENT: _____

PRINTED NAME OF WITNESS: _____ DATE: _____

SIGNATURE OF WITNESS: _____ RELATION/JOB TITLE: _____

Turn over for completion

PATIENT REGISTRATION ____NEW ____UPDATE

CIRCLE AS APPLICABLE

GUARDIAN - MEDICAL POWER OF ATTORNEY

LAST NAME: _____ FIRST NAME: _____

PHONE NUMBER: _____ RELATION/TITLE: _____

OIM MUST HAVE A CERTIFIED COPY OF THE MEDICAL POWER OF ATTORNEY IN YOUR FILE. OIM MUST BE NOTIFIED IN WRITING IN THE EVENT OF ANY CHANGES REGARDING THIS NOTICE.

NEXT OF KIN:

LAST NAME: _____ FIRST NAME: _____

PHONE NUMBER: _____ RELATION: _____

ADDRESS: _____

_____

SIGNATURE OF PATIENT: _____ DATE: _____

Turn over for completion