MEDICAL ARTS ASSOCIATES, P.S

PATIENT DEMOGRAPHICS

NAME: _____ BIRTHDATE (DOB): _____ SEX: Male/ Female

SSN: _____ MARITAL STATUS: Single/ Divorced/ Separated/ Widowed/ Married to: _____

DEPENDENT MINOR: Y/N IF YES, RESPONSIBLE PARTY: _____ PREFERRED LANGUAGE: _____

RACE: WHITE BLACK ASIAN NATIVE AMERICAN/ALASKAN PACIFIC ISLANDER OTHER/MULTIPLE (CIRCLE ONE)

ETHNICITY: HISPANIC NON-HISPANIC (CIRCLE ONE)

HOME ADDRESS: _____ HOME #: _____

CITY: _____ _____ STATE: _____ ZIP CODE: _____ WORK #: _____

EMAIL ADDRESS:_____ MOBILE #: _____

PREFERRED PHARMACY (CITY/PHONE #):_____

HIPAA

NOTICE OF PRIVACY POLICY

We at Medical Arts Associates, P.S., are working to ensure that confidentiality regarding your protected health information and care is maintained at all times. In order to comply with the HIPAA ACT of 1996, we need your signature to allow us to leave a message about your upcoming office visit, account information, and/or any test results via telephone or electronic messaging or to access your healthcare information with secure password through our website link.

ACCESS YOUR HEALTHCARE INFO (SECURE PASSWORD PROTECTED WEBSITE LINK): Y/N

LEAVE MSG ON ANSWERING MACHINE: HOME: Y/N WORKPLACE: Y/N MOBILE PHONE: Y/N
(Note: We need to be able to leave a message on at least one number's voicemail)

SOMEONE AT MY RESIDENCE: Y/N IF YES, WHO CAN WE LEAVE A MESSAGE WITH?:_____

SHARE MY HEALTH INFO. WITH: _____ #:_____

EMERGENCY CONTACT:_____#:_____

INSURANCE INFORMATION

PRIMARY SUBSCRIBERS NAME: _____ DOB: _____ RELATIONSHIP:_____

ACKNOWLEDGEMENT

SIGNATURE: _____ DATE: _____
(Patient or Legal Guardian)

PRINT NAME: _____
(Patient or Legal Guardian)