DeSantis Family Practice, PLLC

PATIENT INFORMATION

☐NEW PATIENT ☐UPDATE

Date: .....

Patient: .....
LAST FIRST MI PREFERRED

☐MALE ☐FEMALE ☐CHILD ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

Patient Date of Birth: ..... Patient SSN: .....

Address: .....
ADDRESS LINE 1

.....
ADDRESS LINE 2

.....
CITY ST ZIP CODE

HOME: .....
CELL: .....
OTHER: .....

E-Mail: .....

Referral? ☐Yes ☐ No Referred by: .....

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL NAME/LOCATION

DEMOGRAPHIC INFORMATION/PREFERENCES

Race: ☐ WHITE ☐ BLACK ☐ ASIAN ☐ AMERICAN INDIAN ☐ OTHER _____ ☐ DECLINED

Preferred Language: ☐ENGLISH ☐SPANISH ☐JAPANESE ☐CHINESE ☐OTHER _____

Ethnic Group: ☐DECLINED/DOES NOT APPLY ☐HISPANIC/LATINO ☐NON-HISPANIC/LATINO

Preferred Method of communication for receiving a Clinical Summary:
☐ PRINT ☐ SAVE TO CHART ☐ PATIENT PORTAL

Preferred Method of communication for receiving Appointment Reminders:
☐ PRIMARY PHONE ☐ ALTERNATE PHONE ☐ PATIENT PORTAL

Preferred Method of receiving health management reminders (flu shot, etc.):
☐ PRIMARY PHONE ☐ ALTERNATE PHONE ☐ PATIENT PORTAL ☐ MAIL

PERSON FINANCIALLY RESPONSIBLE (GUARANTOR)

Name: ..... Relationship: .....

Address: .....
ADDRESS LINE 1

PHONE: .....

.....
ADDRESS LINE 2

.....
CITY ST ZIP CODE

E-Mail:

DeSantis Family Practice, PLLC

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

Tel:

NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:

ADDRESS LINE 1

WORK #: X

ADDRESS LINE 2

CITY ST ZIP CODE

Work E-Mail:

IF PATIENT UNDER 18 YEARS OLD

Mother's Name: _____

Mother's Address

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

Mother's Employer Name

Primary Phone #:

Work Phone #

E-Mail:

Father's Name:_____

Father's Address

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

Father's Employer Name

Primary Phone #:

Work Phone #

E-Mail:

DeSantis Family Practice, PLLC

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of DeSantis Family Practice's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that DeSantis Family Practice has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ **Date:**_____

RELATIONSHIP TO PATIENT: ☐SELF ☐PARENT/GUARDIAN ☐OTHER _____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other – please list:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of my medical records by DeSantis Family Practice, PLLC; for medical claims in agreement with the notice of Privacy Practices. I am responsible for any unpaid balance on my account(s). I understand that fees for visits, examinations, or treatments are payable at time of service unless covered by insurance or arrangements have been made in advance. All telephone numbers and email addresses may be subject to receiving calls and written messages from an automated delivery system. Your signature authorizes consent and permission to contact you via internet and other telecommunication devices.

Signature: _____ Date:_____