New Patient Form

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CONTACT INFORMATION

Name _____ DOB _____

SSN _____ Sex _____ Age _____ Marital Status _____

Address _____City_____State_____Zip_____

Phone _____ Mobile _____ Email _____

DEMOGRAPHICS (We are required to obtain this information)

Race ▢ Asian ▢ African American ▢ Caucasian ▢ Hispanic ▢ Pacific Islander Other _____

Ethnicity ▢ Hispanic ▢ Non-Hispanic **Language** ▢ English ▢ Chinese ▢ Spanish ▢ Vietnamese Other _____

EMPLOYER INFORMATION

Employer _____ Office Phone _____

SPOUSE INFORMATION

Name _____ DOB _____ SSN _____

Employer _____ Office Phone _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Phone _____ Email _____

REFERRAL & CONTACT PREFERENCE How did you hear about our clinic

Name _____ Website _____ Phone Book _____ Hospital _____ Other _____

Is it okay to leave messages on your phone? Yes _____ No _____

HIPPA RELEASE Authorization to release medical information to:

Name _____ Relationship _____

Authorization to Pay Benefits to Physician / Notice of Privacy Practice
I hereby authorize Ike Eni, MD PA office and affiliated or other providers to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration compliance/grievances. I understand that the specific information to be released may include, but is not limited to the diagnosis of Acquired Immune Deficiency (AIDS). I authorize Direct payment to be made to Ike Eni, MD PA on all medical services rendered. I hereby volunteer consent to such healthcare encompassing diagnostic procedures and treatments by my physicians, and/or physician's associates, assistance, and other healthcare providers, As may be necessary in my physician's judgment. I have relied on my physicians for information in this regard and acknowledge that no warranty or guarantee in order to render services. I hereby acknowledge that I have read and/or received a copy of notice of privacy practices.

NO SHOW OFFICE POLICY IS $50.

Patient Signature _____ Date _____