Bay Area Medical Clinic

Patient Information Form

PATIENT NAME AND DOB	
Name (Last, First, MI):	**DOB:**

PERSONAL INFORMATION	
Nickname (if applicable):	**Gender:** ☐ Male ☐ Female
Primary Phone: ☐ Cell Phone ☐ Home Phone ☐ Work Phone	
Cell Phone:	**Home Phone:**
Work Phone:	**Email Address:**
License Number:	**License Expiration:**
License State:	**Social Security Number:**
Florida Residency Status: ☐ Full-Time Florida Resident ☐ Part-Time Florida Resident	
Months in Florida (if Part-Time Florida Resident): ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec	

Local Address:	**City:**	**State:**	**Zip:**
Out-of-State Address:	**City:**	**State:**	**Zip:**

Race: ☐ White ☐ African American ☐ Asian ☐ Declined to Specify ☐ Other: _____	
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to Specify	**Preferred Language:** ☐ English ☐ Spanish ☐ Other: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated	
How Did You Hear About Us?	

INSURANCE	
Insurance Name:	**Member ID Number:**
Policy Holder:	**Group Number:**
Relation to Patient:	**Effective Date:**

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Authorization for Disclosure of Patient Health Information (HIPAA Consent) ***Please list ANY and ALL people that we are allowed to release your medical information to***		
I authorize Bay Area Medical Clinic to disclose medical information pertaining to my care to those that I designate.		
Emergency Contact **Name:**	**Relation:**	**Phone:**
Other Contact **Name:**	**Relation:**	**Phone:**
Patient Signature: _____ **Date:** _____		

Acknowledgement of Notice of Privacy Practices
A Notice of Privacy Practice Policy that provides a complete description of protected health information uses and disclosures is available upon request. I understand that I have the right to view my medical records and restrict how my health information may be used or disclosed.
Patient Signature: _____ **Date:** _____

Insurance Release and Payment Agreement
I authorize the release of any medical records or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I recognize and accept responsibility for the payment of any balance remaining after payment of such benefits that are my responsibility.
Patient Signature: _____ **Date:** _____

Consent to Obtain Prescription History
I authorize Bay Area Medical Clinic and its affiliated providers to view my external prescription history via the RX History service. I understand that my history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and the staff of Bay Area Medical Clinic, and it may include prescriptions back in time for several years. My signature certifies that I have read and understand the scope of my consent and I authorize access.
Patient Signature: _____ **Date:** _____