SOUND MEDICAL FAMILY PRACTICE
Patient Information

Patient's Last Name: _____ **First:** _____ **Middle I:** ____ **Social Security #** ____-____-____

Marital Status S / M / D / W

Mailing Address: _____ **City** _____ **State** _____ **Zip** _____ **Sex:** ☐ M ☐ F **Age** ____ **Birth Date:** __-__-__

May we leave a medical message about your healthcare on Your voice mail? ☐ Yes ☐ No

☐ Home Phone ( ) _____-_____

☐ Cell Phone ( ) _____-_____

Employment Information: ☐ Retired

Employer:_____

Occupation:_____

Work Phone:_____ EXT_____

Emergency Contact Information:

Name_____

Relationship_____

Phone # ( ) _____

Phone # ( ) _____

May this emergency contact have Access to your medical records?

☐ Yes ☐ No Initial_____

What is your preferred pharmacy?

_____

Email Address: (used for office communication)

_____

Would you like to have access to our patient portal? ☐ Yes ☐ No

Race:
- ☐ White/Caucasian
- ☐ Black
- ☐ African American
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ American Indian
- ☐ Alaska Native
- ☐ Other Race
- ☐ Decline

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Decline

HIPAA Acknowledgements:

Please initial each line:

____ I hereby acknowledge that I have been provided with a copy of the privacy policy
____ I elect the following people below to have access to my medical records:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Deemed Consent-Consent for treatment-Release of Medical Information-No Guarantee-Electronic Communications

I hereby authorize medical treatment by any Sound Medical Family Practice Physician, Physician Assistant, and or affiliated medical staff member. I further authorize release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier. I accept responsibility for payment of all treatment that the insurance carrier determines does not constitute as covered services. I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment. I agree that Sound Medical may request and use my prescription
medication history from other healthcare providers or third-party pharmacy benefit organizations for treatment purposes. We will send you appointment reminders and other important electronic messages by text and email.

By providing your email address and cell phone number, you consent to receive electronic messages by such means. We will not share your information. You may opt out of electronic communication at any time.

If the patient is a minor or has a power of attorney, who is the responsible party for this patient:

Name: _____Relationship to patient_____Birth Date____-____-____

Signature of Patient or Responsible Party X **Date**____-____-____