I & O Medical Centers

In and Out Express Care

Please fill out completely ***Time In:*** _____

Patient's Name: _____ *(First, Middle initial, Last)*

Address: _____ **City:** _____**State:** _____**Zip:** _____

Phone: (_____) _____(H) Phone: (_____) _____ (C) Email Address: _____

Would you like to receive updates, lab reports, or provider correspondence via email? (Circle one) **YES** **NO**

How did you hear about I & O Medical Centers? _____ **Preferred Language**: _____

DOB: _____ **SSN:** _____ **Sex**: M F **Race:** _____

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Decline single / married / separated / divorced / widowed

Spouse Name (or parent if minor): _____ **Phone: (_____) _____**

Emergency Contact: _____**Relationship**: _____ **Phone: (_____) _____**

PATIENT'S EMPLOYER: _____ **Phone: (_____) _____**

Address: _____ **City:** _____**State:** _____**Zip:** _____

Medical Insurance

Primary Insurance: _____ **Secondary Insurance:** _____

Policy Holders Name: _____ **Policy Holders Name:** _____

SSN: _____ **DOB:** _____ **SSN:** _____ **DOB:** _____

ID #: _____ **ID #:** _____

HIPAA Disclosure:

Under HIPAA privacy rule, I & O Medical Centers are required by law to maintain the privacy of individuals and provide this notice of our legal duties and privacy practices with respect to protected health care information.

For all health care information I would like to be contacted by: ☐ **PHONE** ☐ **EMAIL** _____

I authorize I & O Medical Centers to release medical information about me to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ **Date**: _____