Maxa Internal Medicine

ADDITIONAL PATIENT INFORMATION

Last Name_____ First Name_____

Date of Birth_____/_____/_____

Email Address_____@_____ (For access to Our New Patient Portal)

Race:

____ American Indian or Alaska native ____ Black or African American ____ Other Race
____ Asian ____ White ____ Refused to report
____ Native Hawaiin/Pacific islander ____ Hispanic

Ethnicity: _____ Hispanic or Latin _____ Non Hispanic _____ Refused to report

Language: _____ English _____ Spanish _____ French _____ Japanese _____ Chinese ___Other_____

Pharmacy Name: _____ **Street and City**:_____

I wish to be contacted in the following manner (check all that apply)

_____ Home Telephone: _____

_____ O.K. to leave message with detailed information (Extended)

_____ Leave message with call-back number only (Brief)

_____ Cell Phone: _____

_____ O.K. to leave message with detailed information (Extended)

_____ Leave message with call-back number only (Brief)

_____ Work Telephone:

_____ O.K. to leave message with detailed information (Extended)

_____ Leave message with call-back number only (Brief)

HIPPA:

Please list any individual(s) you would like for your personal healthcare information to be disclosed. **NOTE:** If you do not list anyone, we may ONLY release information to you.

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