DOCTORS OF INTERNAL MEDICINE

The American Recovery and Reinvestment Act of 2009 requires us to obtain personal information. The information obtained below will help us comply with this act and will only be used for this purpose.

_____ _____

NAME (please print) **DATE OF BIRTH**

Please circle Race:
1. White
2. Black/African American
3. Asian
4. American Indian/Alaska Native
5. Native Hawaiian/Other Pacific Islander
6. Other Race
7. Declined

Please circle Ethnicity:
1. Hispanic/Latino
2. Not Hispanic/Latino
3. Declined

Current Phone Numbers:
Home: _____-_____-_____ **Cell:** _____-_____-_____ **Work:** _____-_____-_____

Preferred Contact Method (circle one): Home / Cell / Work / Regular Mail

Preferred Reminder Method (circle one): Home / Cell / Work / Regular Mail

Will you allow us to leave personal health information at your preferred contact method? Yes / No _____ (initials)

Current Mailing Address: _____ _____
Street address City, State, Zip code

Informed Consent to use Patient Portal

The purpose of the Patient Portal is to allow communication through the internet between Doctors of Internal Medicine and our patients in a secure and HIPAA-compliant manner. It is an optional service, and we reserve the right to suspend or terminate it at any time. We will alert you of any changes as promptly as possible. By signing below, you confirm that you have read, understand, and agree to comply with our policies and procedures for using the Patient Portal. You also agree not to hold Doctors of Internal Medicine or any of their staff liable for network infractions beyond their control.

_____

EMAIL ADDRESS (Print clearly and notify us with any changes)

_____ _____

PATIENT SIGNATURE **DATE**

Consent to Obtain Medication History

By signing below, you give Doctors of Internal Medicine permission to obtain your medication history from your pharmacy, health insurance plans and other healthcare providers. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

_____ _____

PATIENT SIGNATURE **DATE**