Associates in Internal Medicine
825 Washington Street
Norwood, MA 02062

Patient Information

Last Name: **First Name:** **MI:**

Home Address:

Home Phone: **Work Phone:** **Cell Phone:**

Date of Birth: **Sex:** **Marital Status:**

Email Address:

Primary Care Physician:

Emergency Name: **Phone:** **Relation:**

How would you prefer to be contacted for appointment reminders? **Phone** **Text** **(circle one)**

Due to a change in recent Federal regulations and Medicare guidelines, we are required to ask the following 3 questions. (There is an option below if you would prefer not to report):

Primary Language: _____

Race: *Please select one*

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Other Race: _____
- ☐ White
- ☐ Hispanic
- ☐ Prefer Not To Report
- ☐ Asian
- ☐ Native Hawaiian

Ethnicity: *Please select one*

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Prefer Not To Report

Insurance Information

Insurance Name:
Subscriber Number:
Group Number:
Insurance Address:
Subscriber:
Subscriber's Name:
Subscriber's Social Security Number:

Secondary Information

Insurance Name:
Subscriber Number:
Group Number:
Insurance Address:
Subscriber:
Subscriber's Name:
Subscriber's Social Security Number:

Please list your preferred pharmacies:

	NAME	ADDRESS
Local:		
Mail Order:		

Associates in Internal Medicine
825 Washington Street
Norwood, MA 02062

Patient:

HIPAA Notice of Patient Privacy Practices

I acknowledge receipt of the practice privacy notice. I may request an additional copy of the privacy notice at any time. (Copies are available at all times at the check-in window of any of our offices)

Signed _____ Date: _____

Permission to Communicate with Your Primary Care Physician, Other Community Care Providers and/or Mental Health Providers:

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or Health Insurance Company.

Signed _____ Date: _____

Consent for RX Hub Inquiry

I hereby provide my consent for the practice to obtain my Rx History using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Signed _____ Date: _____