WESTSIDE INTERNAL MEDICINE, LLC

PATIENT INFORMATION

(Please Print)

Name: ______________________________ Date of Birth: ______________ Age: ________

(Last) (First) (Initial)

Address: ____

(Street) (City) (State) (Zip)

SEX: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W Social Security #: ____________________

Home Phone: _________________ Cell Phone: _________________________

Employer: ____________________________________ Work Phone: ________________

Emergency Contact: _____________________________________(__)_______________

(Name) (Relationship) (Phone)

Race: _____________ ☐ Hispanic ☐ Non-Hispanic Language Preferred: ________________

Do you rely on transportation such as AmbuStar, Logisticare, etc.? ☐ Yes ☐ No

How did you hear about our practice? ____

Insurance? Name: _________________ Member/Subscriber No.: _____________________

Previous Primary Care Provider? Name: _____________________ Phone: _________________

Do you give permission to this office to leave a message regarding your appointments, medication and/or lab results?

Home Phone ☐ Yes ☐ No Cell Phone ☐ Yes ☐ No Initial __________

Email: ____

I hereby consent to treatment by the physicians and/or associates of Westside Internal Medicine.
I hereby assign my insurance benefits to be paid directly to Westside Internal Medicine. I understand that I am financially responsible for all charges not covered by the assignment. Submitted New Patient paperwork does not constitute a Physician-Patient Relationship. All patients must be seen by one of our Providers to establish a Physician-Patient Relationship.

Signature: ____________________________________ **Date:** ________________