NW Metabolic Medicine
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nwmetabolic.com

PATIENT DEMOGRAPHIC INFORMATION

Today's Date

Patient Name (Last, First, Initial)	☐ Male ☐ Female	Date of Birth	Age

Address	City	State	ZIP Code

Cell Phone (Include Area Code)	Work Phone (Include Area Code)	Home Phone (Include Area Code)

☐ If Under Age 18	Parent/Guardian Name	Relationship to Patient

If checked, you must complete "Consent for Treatment of Minor" form.

APPOINTMENT REMINDERS

☐ I wish to have phone call reminders (☐ Cell Phone ☐ Home Phone)
☐ I wish to have text messaging reminders (complete Electronic Communications authorization)
☐ I wish to have E-mail reminders (complete Electronic Communications authorization)
☐ I do not wish to have an appointment reminder and will accept any charges associated with missed appointments

EMERGENCY CONTACT INFORMATION

Name of Relative / Friend	Relationship to Patient	Phone

PHYSICIAN AND PHARMACY INFORMATION

Primary Care Physician	City & State	Preferred Pharmacy	City & State

MEDICARE STATUS

☐ I am enrolled in Medicare Part B (complete Medicare Private Contract)

INSURANCE INFORMATION

Health Insurance Company Name

HIPAA NOTICE OF PRIVACY PRACTICES – PATIENT ACKNOWLEDGEMENT

A complete description of Northwest Metabolic Medicine's privacy practices is available at our office in print form, or on our website: http://nwmetabolic.com.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy in regards to my personal health information (PHI). I have received, read, and understand the HIPAA Notice of Privacy Practices.

Northwest Metabolic Medicine (NWMM) reserves the right to change its privacy practices by changing the terms of the notice. I understand that NWMM will provide a current Notice of Privacy Practices upon request.

_____	_____	_____
Print Name	Patient or Authorized Representative Signature	Date