Affiliated Physician
MDVIP

Lara Hitchcock, MD, FAAFP
Family Medicine

Hitchcock Health Institute

New Patient Intake Form

Today's Date: __

Name: _____ DOB: _____ Last 4 of SSN: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Primary Phone: _____ Secondary Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Employer: _____ Work Phone: _____

Insurance Information

Insurance Company Name: _____ Policy ID #: _____

Insurance Address: _____ Phone (back of card): _____

Policy Holder: _____ Policy Holder DOB: _____ Relationship: _____

Emergency Contact

Name: _____ Phone Number: _____ Relationship: _____

Notice of Privacy Practices

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk. You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or healthcare operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice. By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Information Disclosure and Consent

I acknowledge and agree that the practice may disclose my protected health information and medical record information to the following individual(s) who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf. *If none, please write "none" and initial*

Name(s):_____

_____

I understand this office may utilize automated messages and I authorize to be contacted in such a manner. I read and agree to all of the above (Insurance Information, Notice of Privacy Practices, and Information Disclosure and Consent)

Signature: _____ Date: _____

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