New Patient Info – Receipt Of Privacy Policies

First Name: _____ Last Name: _____

Date of Birth: ____/_____/_____ ❑ **Male** ❑ **Female**

Cell #:_____ Home #: _____

Address: _____

City _____ State _____ Zip _____

E-Mail: _____

Emergency Contact: _____

Phone: _____ Relation: _____

Preferred Pharmacy: _____

Street_____ City _____

Primary Care or Family Doctor: _____ City: _____

"I acknowledge that a copy of the OM Medical Group, PC Privacy Policy is posted in the office and a copy has been provided for me. Protecting the privacy and confidentiality of patient's personal information is very important to the providers and staff at this clinic. I understand I am encouraged to contact the Privacy Officer for any questions or concerns I might have."

SIGNATURE: _____ DATE: _____/_____/_____