LITTLETON INTERNAL MEDICINE ASSOCIATES
WELCOME TO OUR OFFICE

PLEASE PRINT AND COMPLETE ALL PARTS

Today's Date:_____

PATIENT NAME: (This section refers to PATIENT ONLY)

Name:_____ Date of Birth: _____ Age:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell:_____

Race: _____ Ethnicity: _____ Preferred Language _____
E-mail:_____ Sex:_____ Social Security #:_____

Employer:_____
Spouse:_____
Spouse Employer:_____
Spouse Work Phone:_____

Check One:
Relationship to Responsible Party:
☐Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____

POLICY HOLDER: (Person who should receive bill)
Name:_____ Date of Birth:_____ Age:_____
Address:_____ City:_____
_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell:_____

Social Security Number:_____ Employer:_____

NOTIFY IN EMERGENCY:
Name:_____ Relationship:_____ Phone:_____

I give Littleton Internal Medicine Associates, PC permission to leave all X-ray, appointments, lab results and other medical information and advice on (check all that apply)

☐ Voicemail at work ☐ Answering machine at home ☐ Cell phone
☐ Okay to leave message with family member What is family member's name:_____
☐ Do not leave a message ☐Other _____ / phone number _____
Relationship to Patient: ☐ Self: ☐ Parent ☐Guardian

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
Name of Patient (please print)_____
Date of Birth:_____

I hereby acknowledge that I am aware of Littleton Internal Medicine Associates' Notice of Privacy form which was offered to me.

_____ _____
Signature of Patient or Patient Representative Date