SOLE HEALTH

DEMOGRAPHIC FORM

Demographics:

Last Name: First Name: MI:

Address:

City: State: Zip:

Date of Birth: Sex: Male Female Transgender

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered

Contact Information:

Home Phone: Cell Phone:

Email Address for Patient Portal Use:

Emergency Contact Name: Emergency Contact Phone:

Relation to You:

Preferred Language:

☐English ☐Spanish

How did you hear about us? _____

CONSENT FOR PHOTO IDENTIFICATION:

I consent to Sole Health taking a digital photograph of my face for purposes of patient identification. The digital photograph will remain with my electronic medical chart and will not be used for other purposes without my authorization.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD AND AGREED TO THE FOREGOING.

_____

Date Signature of Patient

SOLE HEALTH

Phone Message Consent

Your provider or office staff will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

Patient's Full Name: _____

In an effort to protect your privacy, we have developed a policy on leaving medical care messages:

• We will NOT leave messages with anyone except the patient or legal guardian,

• We will NOT leave any confidential information on an answering machine,

• We will NOT leave any messages on a voicemail

, UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO Please read the below and consider carefully whom you authorize to have access to protected information regarding your care.

I, _____ give Sole Health my permission to speak with and/or leave messages regarding my medical care and/or billing with the person(s) listed below. I fully understand that this consent will remain valid until revoked in writing:

My Home answering machine # _____ Initials: _____

My Cell Voice Mail #_____ Initials: _____

My Office/Work VM #_____ Initials: _____