Patient Demographics

NORTHERN NEVADA *Medical Group*

Patient information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle) M / F	Date of Birth	Marital Status (circle) Divorced - Married - Separated - Single - Widowed - Other	Preferred Language

Race (check all that apply) ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Patient Declined

Ethnicity (check all that apply) ❑ Hispanic or Latino ❑ Multiple ❑ Not Hispanic or Latino ❑ Patient Declined

Mailing Address	Apt/Lot	City/State	Zipcode	Phone #s: Home ( ) Mobile ( ) Work ( )

Email Address	Primary Physician	Preferred Pharmacy

Responsible Party/Parent/Guardian (circle one) Check if same as [ ] Patient

Last Name	First Name	Gender (circle) M / F	Date of Birth	What is Patient's relationship to responsible party?

Mailing Address	Apt/Lot	City/State	Zipcode	Phone #s: Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City/State	Zipcode

Emergency Contact Check if same as [ ] Responsible Party

Last Name	First Name	Phone #s: Home ( ) Mobile ( ) Work ( )	What is Patient's relationship to emergency contact?

Insurance Information Check if [ ] Self pay

Primary insurance: Check if same as: [ ] Responsible Party			**Secondary insurance:** Check if same as: [ ] Responsible Party	
Insurance Name		Begin date	Insurance Name	Begin date
Subscriber/Member Name		Date of Birth	Subscriber/Member Name	Date of Birth
What is Patient's Relationship to Subscriber?		Gender (circle) M / F	What is Patient's Relationship to Subscriber?	Gender (circle) M / F
Insurance Mailing Address	City/State	Zipcode	Insurance Mailing Address	City/State Zipcode
Subscriber/Member #		Group #	Subscriber/Member #	Group #

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION - I hereby authorize Northern Nevada Medical Group to furnish the insured's insurance company all information in which the said insurance company may request concerning my present illness or injury. I hereby assign to the providers all money to which I am entitled for medical and/or surgical expenses relating to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said providers for all charges. I hereby authorize Northern Nevada Medical Group to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

Who referred you to our office: ❑ Primary Care ❑ Other: _____

_____ _____

Patient/Legal Guardian Signature Date Patient/Legal Guardian Print

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Patient Consent

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis. (Including treatment, payment, and healthcare operations.

   _____

   _____

   _____

2. Please list family members or significant others, if any, whom we may inform about your medical conditions **only in an emergency**.

   Name: _____Phone # _____
   Name: _____ Phone#_____

3. Please indicate if you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL: [ ] yes [ ] no

4. Please print the telephone number where you want to receive calls about your appointments, labs, x-rays, or other health care information, if other than your home phone number ( )_____

5. ****I am fully aware that a cell phone is not a secure and private line****

6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voice mail? [ ] yes [ ] no

7. By signing this form, you acknowledge that NNMG has offered you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

8. By signing this form, I acknowledge receipt of the NNMG Financial Policies and agree to abide by them as written.

9. By signing this form, I acknowledge receipt of the NNMG Patient Rights and Responsibilities

Print your name _____**Date**_____

Patient Signature _____

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NNMG Patient Portal

- **Request medication refills**
- **Send and receive secure messages from your care team**
- **Request appointments**
- **View your medical record...and more**

Name _____ **DOB:** _____/ _____/ _____

To receive an invitation to register for the patient portal please provide us with the following information:

E-mail Address (please print clearly):

_____

To opt out of the patient portal please check one of the options below:

_____ I am not interested in signing up for the portal at this time

_____ I do not have an e-mail address