OXMOOR MEDICAL GROUP
BECAUSE PEOPLE MATTER

PATIENT INFORMATION

Name: Last _____ First _____ Middle _____
Birthdate _____ SSN _____ Sex _____
Phone: ☐ Home _____ ☐ Work _____ ☐ Mobile _____
Preferred method of contact (check all that apply): ☐ Phone ☐ Text ☐ Email
Address _____ City _____ State _____ ZIP _____
Email _____ Race _____ Martial Status _____
Emergency Contact and Number _____ Relationship _____
Employer _____ Employer Number _____
Spouse's Name (if married) _____ Spouse's Employer _____
Relatives/friends who are patients here? _____ Who referred you? _____

INSURANCE INFORMATION

Insurance Company (Primary) _____
Policy Holder's Name _____ Birthdate _____
Contract Number _____ Group Number _____
Insurance Company (Secondary) _____
Policy Holder's Name _____ Birthdate _____
Contract Number _____ Group Number _____

CONSENT FOR TREATMENT

I consent to necessary treatment, including the administration of medication and the performance of X-ray or other studies that may be used by the attending physician, nurse, or staff.

CONSENT FOR ELECTRONIC COMMUNICATION

I consent to the use of electronic communication, including text messaging, emailing, and video conferencing for telehealth.

CONSENT FOR E-PRESCRIBING

I have been made aware and understand that the medical practice and office staff may use an electronic prescription system that allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers who use this electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

NON-COVERED SERVICES AGREEMENT

I understand that certain routine services performed during my appointments, such as DEXA scans, pap smears, biopsies, ultrasounds, X-rays, lab work, injections, and/or other testing necessary for the maintenance of my health may not be covered by my insurance. By signing below, I agree that I will be responsible for costs not covered by my insurance.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____
Patient Signature Date