INTERNAL MEDICINE
ASSOCIATES of TEXAS

Ambareen Salam, M.D
Denise Young, FNP-C

Patient Registration Form

Name: ____
(Last) (First) (Middle)

Name you prefer to be called: ____

Date of Birth______/______/_____ Social Security Number___________________ Sex: M or F

Marital Status _________ Dominant Hand _________ Language Preferred _______________

E-mail Address: ____

Phone: Work_____________________ Home__________________ Cell___________________

Mailing Address____

City, State, Zip (+4) ____

Emergency Contact Name_______________________ Phone Number____________________

Emergency Contact/Relationship to Patient____

Whom shall we thank for referring you to our office? __________________________________

INSURED PARTY INFORMATION (if different from patient information)
Insured Party Name: ____

Date of Birth______/______/_____ Social Security Number___________________ Sex: M or F

PREFERRED PHARMACY:
Pharmacy Name: ___________________________Phone Number ______________________

Address ____

Internal Medicine Associates of Texas, 7777 Forest Lane Suite C-650, Dallas, TX 75230
Phone: 972-566-8899, Fax 972-566-5775

DISCLOSURE AUTHORIZATION

As stipulated by the HIPAA privacy rule, patients have the right to control how and to whom their protected medical information is given. Please instruct below how you would like the staff at Internal Medicine Associates of Texas to contact you.

I wish to be contacted in the following manner:

☐ OK to leave message with detailed information at home
☐ OK to leave message with call back number only at home

☐ OK to leave message with detailed information at work
☐ OK to leave message with call back number only at work

☐ OK to mail to my home address

WHOM TO CONTACT

In order to further protect your privacy, we will only disclose and/or discuss your healthcare information to members of your family, or others close to you, if you authorize us to do so.

Therefore, if you permit Internal Medicine Associates of Texas to disclose information related to your medical condition(s) please list their information below:

Name____________________Relationship________________Phone__________________

Name____________________Relationship________________Phone__________________

Name____________________Relationship________________Phone__________________

☐ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

____

Printed Patient Name Date of Birth

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Signature of Patient or Legal Representative Date

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Information Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with this important information. For a complete guide of the privacy practices of our office regarding your health information rights, please review the notebook in the waiting room. If you would like a copy to retain for yourself please request this from our front desk staff.

I acknowledge that I have been presented with the Notice of Privacy Practices as well as the Office Protocol and understand my responsibilities.

____

Printed Patient Name   Date of Birth

____

Signature of Patient or Legal Representative   Date

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