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NEW PATIENT INFORMATION

REFERRED BY DR. _____ DATE: _____

PATIENT NAME: _____ SEX _____ D.O.B. _____ AGE _____

ADDRESS: _____ S.S. # _____ - _____ - _____

CITY _____ STATE _____ ZIP _____ PHONE _____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED

EMPLOYER _____ PHONE _____

JOB TITLE _____ DATE LAST WORKED _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

EMERGENCY CONTACT _____ PHONE _____

NOTICE OF PRIVACY PRACTICE

Our Duties

We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be made available to you at our imaging center or from our Privacy Coordinator by calling (813) 238-3833 or by writing to AFO Imaging c/o Privacy Coordinator, 1931 W. M.L.K. Blvd, Ste F, Tampa, Florida, 33607.

Patient Acknowledgment

I hereby acknowledge that I have been given an opportunity to review the privacy practices at Advanced Imaging. I understand that I may obtain a copy of the Notice of Privacy Practices. This notice has been issued and considered effective on the date signed. We will keep this form on file for a minimum of seven (7) years.

Patient Signature

Date