IMCC

WELCOME TO IMCC

NAME_____
First **Middle Initial** **Last**

ADDRESS_____**APT #**_____

TOWN_____**STATE**_____**ZIP CODE**_____

HOME PHONE # _____**WORK PHONE #** _____**CELL PHONE #**_____

DATE OF BIRTH_____ **AGE**_____**SOCIAL SECURITY #**_____

MARITAL STATUS_____ **Male/Female**_____ **OCCUPATION**_____

EMPLOYER_____**PHONE #**_____

E-MAIL ADDRESS_____

ALLERGY TO MEDICATIONS_____
(please specify or state NONE)

PRESENT MEDICATIONS_____
(please specify or state NONE)

TETANUS BOOSTER WITHIN THE LAST 5 YEARS NO ____YES ____ INDICATE YEAR _____

REASON FOR THIS VISIT_____

SIGNATURE: _____**TODAY'S DATE**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received and reviewed a copy of IMCC's Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative

Relationship to patient

FOR CLINIC USE ONLY: **IMCC** made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices: **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]**