New Patient Registration

Last Name:	First Name:	Middle Initial:	
Date of Birth: SSN:	Sex: (Male/Female) Gender at Birth: (Male/Female) Gender Identity: (Male/Female) Sexual Orientation:		
Street Address:		Zip Code:	
Home Phone:	Work Phone:	Cell Phone:	Text: Yes | No
Contact Preference: Home | Cell | Work | Mail | Portal	Hispanic/Latino: Yes | No	Email:	
Marital Status: Married | Single | Divorced | Separated | Widowed | Partner	Language:	Race:	
Occupation:	Employer:	Phone:	
Primary Care Physician:	Specialists:	Preferred Pharmacy: (Name, Street, City, Phone	
How did you find out about Dr. Malik?			
Emergency Contact:	Relation:	Phone Number:	

Please Fill Out Insurance Policy Holders Information Below (if other than yourself):

Name: _____ Relation: _____

Date of Birth: _____ Address: _____

With whom we may discuss your medical information (non-healthcare providers, family members, friends, etc)?

Name: _____ Name: _____

Relation: _____ Relation: _____

Phone: _____ Phone: _____

Type of Access: ☐ Full ☐ Limited _____ Type of Access: ☐ Full ☐ Limited _____

I hereby authorize Virginia Gastroenterology Institute, PC. to disclose and discuss my protected health information with the persons I have listed on this form. I understand that this consent is voluntary and is not required in order for me to receive treatment. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information may no longer be covered by these laws and may be re-disclosed by the recipient. I understand that I may revoke this authorization, except to the extent that action has already been taken, at any time by sending written revocation of authorization to Virginia Gastroenterology Institute, PC.

By signing below, I agree that the above information is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

Form Last Updated: January 2019

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Obici- 2790 Godwin Blvd. Suite 205, Suffolk, VA 23434

Virginia Gastroenterology Institute

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I acknowledge that I have received Virginia Gastroenterology Institute's Notice of Privacy Practices, which describes the ways in which the business may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures.

I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint.

Name [please print]: _____

Signature: _____

Date: _____