INTERNAL MEDICINE

Robert J. Bloomberg, MD **Sue Hsieh, NP** **Tina Baldwin, NP** **Wendy Tee, NP**

Full Legal Name:_____ Nickname: _____

Address:_____ Apt #_____ City: _____ State:_____ Zip:_____

Primary/Daytime Ph # (_____) _____ - _____ Alternate Ph # (_____) _____ - _____

Date of Birth: ____/____/____ Social Security #: ____ - ____ - _____ Gender: Male ☐ Female ☐

Email Address (please print): _____

Pharmacy Name: _____ Pharmacy phone (_____) _____ - _____

Other family members seen here: _____

Emergency Contact: _____ Phone (_____) _____ - _____

Primary Language Spoken: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic
☐ Declined

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black
☐ Caucasian ☐ Pacific Islander ☐ Other ☐ Declined

I acknowledge that this office <u>does not</u> verify my insurance coverage and I am aware that I am responsible for any medical charges. By signing this I authorize appropriate examination and treatment for problems identified on this and subsequent visits.

Signature: _____ Date:_____

I have been made aware of the office's Notice Of Privacy Practices and a copy has been available to me.

Signature: _____ Date: _____