Oberlander and Associates
Internal Medicine, Inc.

Date: _____

Please complete the form in its entirety. Thank you!!!

Patient Information

❒Dr. ❒Miss ❒Mr. ❒Mrs. ❒Ms. Referred By (If applicable):_____

Last Name:_____ First Name:_____Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone:(____) _____-_____ Cell Phone:(____) _____- _____ Work Phone: (____)____-_____ Ext:_____

Birthdate:_____/____/ _____ Gender: ❒ Male ❒ Female ❒ Transgender ❒ Unknown Marital Status:
❒Single ❒ Married ❒Partner
❒ Separated ❒ Divorced ❒Widowed

SSN: _____- _____- _____

Address if different from Mailing Address:

Street Address: _____ City: _____State: _____Zip: _____

Email Address: _____ ❒None ❒ Prefer not to disclose

Hearing Impaired: ❒ Yes ❒ No Vision Impaired: ❒Yes ❒No

Employer Information:

Employer Name: _____ Phone: (____)- _____ - _____
Employment Status:
❒Employed ❒Full Time ❒Part Time ❒Retired ❒Self Employed ❒Unemployed ❒Active Military
❒Student ❒Full Time ❒ Part Time

Insurance Information ❒ Self Pay (No Insurance) *Please present insurance cards to the front desk*

Primary Insurance: _____Secondary Insurance: _____+__

Subscriber: _____ Relation: _____ Subscriber: _____ Relation: _____

Gender: ❒Male ❒Female Birthdate: ____/_____/____ Gender: ❒Male ❒ Female Birthdate:____/____/____

SSN: _____-_____- _____ SSN: ____-_____-_____

Do you have any advanced directives? ❒Yes ❒No *If yes, please provide a copy of all available directives to the Front Desk. Thank You!*

Please continue on page two (2) of this form. Thank You!

Patient Name: _____

Pharmacy Information

Name:_____ Phone#:_____

Street:_____ City _____State _____ Zip _____

Confidential Communications

I hereby request to receive confidential communications from Oberlander and Associates Internal Medicine, Inc. in the following manner:

Telecommunications/E-mail:

❒ Web enable this account using Oberlander and Associates Internal Medicine's patient portal.

Please leave messages as follows (check all that apply):

❒ Home Phone of Record ❒ Brief ❒ Extended

❒ Work Phone of Record ❒ Brief ❒ Extended

❒ Cell Phone of Record ❒ Brief ❒ Extended

Postal Communications:

Please mail my protected health information to me at (Select only one):

❒ Mailing Address of Record ❒ Street Address of Record ❒ Other as follows

Address: _____ City: _____ State: ____Zip: _____

Your Protected Health Information Designees:
If you are not available at the time we call, please list below those individual (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information).
This person (designee) will also be able to call the office on your behalf. If you are hospitalized, this person (designee) will be able to speak with the physician on your behalf.

Designee Name:	Relationship to Patient	Phone Number	Emergency Contact?
			❒Yes ❒ No
			❒Yes ❒ No
			❒Yes ❒ No
			❒Yes ❒ No
			❒Yes ❒No

_____ Check here if you **do not want** your health care information discussed with anyone other than yourself.

Individuals as listed on page one (1) of this form

I understand Oberlander and Associates Internal Medicine will notify me if Oberlander and Associates is unable to comply with my request. I also understand that my protected health information may be released as my physician determines appropriate in an emergency situation. I have received the Notice of Privacy Practices at Oberlander and Associates Internal Medicine, Inc. ❒ **Yes** ❒ **No** **Initials _____**

I authorize the providers of Oberlander & Associates Internal Medicine, Inc. to provide any medical care deemed necessary according to their professional opinions. I authorize Oberlander & Associates Internal Medicine, Inc. to obtain medication history from my pharmacy(s) as part of my necessary medical care.

Insurance Assignment and Acknowledgement:

I understand my insurance carrier can choose to assign benefits to Oberlander and Associates Internal Medicine, Inc. or my insurance carrier my make payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles, and/or charge for non-covered service provided to me. I am also responsible for providing up-to-date and accurate insurance information.

Medicare and Medicaid: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment.

By signing below, I certify I will pay to Oberlander and Associates Internal Medicine, Inc. any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to Oberlander and Associates Internal Medicine, Inc. any payment that I receive from my insurance carrier for services provided to me. I will also be responsible for any amounts not paid by insurance for my failure to provide the appropriate insurance information for billing.

Patient Printed Name (*if 18 and older)*: _____

Patient Signature (*if 18 and older)*: _____ Date: _____

Guarantor Printed Name (*if applicable):* _____

Guarantor Signature (*if applicable):* _____ Date: _____

Additional Information Regarding Disclosure
Of Patient Medical Information

Oberlander and Associates Internal Medicine, Inc. honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Sending Authorizations to Oberlander and Associates Internal Medicine, Inc:

Oberlander and Associates Internal Medicine, Inc.
6075 East Broad Street
Columbus Oh 43213

Verbal Communication Only: This authorization allows for verbal communication (both in person and on the telephone between Oberlander and Associates Internal Medicine and the designated person(s) on this form. It does not allow for copies of medical records to be released.

Voice Mail Messages: Oberlander and Associates Internal Medicine Providers and their staff recognize confidentiality as a very important part of your relationship with them. To protect your confidentiality, they will not routinely leave messages on your personal messaging system (voice mail or answering machine or with your spouse, family members or any other individual) unless you specifically give your permission to do so. This authorization may be used to share this information in the manner that you specify.

Patient Portal: Your email that you provide is for the specific use of Oberlander and Associates Internal Medicine providers and staff for the sole purpose of communicating with you regarding your health. This information will not be shared. Aprima Patient Portal is a secured website that uses SSL when logging in to maintain security.

No Obligation to Sign: You are under no obligation to sign this form, and you may refuse to do so for either all or part of it. Except as permitted under applicable law, Oberlander and Associates Internal Medicine providers may not refuse to provide you treatment or other healthcare services if you refuse to sign.

Revocation: You have the right to revoke this authorization, in writing at any time. However, your written revocation will not affect any disclosures of your medical information that the person(s) listed on the release form have already made, in reliance on this authorization, before the time that you revoke it.