ONTARIO MEDICAL ASSOCIATES
JEFFREY C. PITTS, MD

PATIENT INFORMATION

****PLEASE PRINT CLEARLY****

Date_____

Patient Name: _____ Date of Birth: _____ Sex: __ Female __ Male

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

Patient Phone: _____ Cell: _____

Patient's SSN: _____ Email: _____

Employer: _____ Employer Phone: _____ Occupation: _____

Marital Status: ___ Single ___ Married ___ Other Spouse's Name: _____

PRIMARY INSURANCE

Name of Carrier: _____ Policy #: _____

Member Name: _____ Birthdate: _____

SECONDARY INSURANCE

Name of Carrier: _____ Policy #: _____

Member Name: _____ Birthdate: _____

Do you give authorization for another person to receive your Private Health Information? ___Yes ___No

Authorized Person: _____

Authorized Person: _____

Referring Provider: _____ Telephone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about us? _____

I was offered a copy Ontario Medical Associates HIPAA Privacy Act effective date 9/23/2013

Signed (Patient or Parent if Minor): _____ Date: _____