LITTLETON INTERNAL MEDICINE ASSOCIATES WELCOME TO OUR OFFICE

PLEASE PRINT AND COMPLETE ALL PARTS

Today's Date:	-		
PATIENT NAME: (This section refers to PATIE	NT ONLY)		
Name: Date		Date of Birth:	Age:
Address:			
City:			
Home Phone:			
Race:	Fthnicity:	Preferred Lang	uage
E-mail:	•	Social Security #:	
Employer:			
Spouse:			
Check One:			
Relationship to Responsible Party:			
□Self □ Spouse □ Son □ □	Daughter		
POLICY HOLDER: (Person who should rece	eive hill)		
Name:	•	Age:	
Address:			
Home Phone:			
Social Security Number:	Employer:		
NOTICY IN EMERCENCY.			
NOTIFY IN EMERGENCY: Name:	Relationship:	Phone:	
Name	Relationship	FIIOHE	
I give Littleton Internal Medicine Associates, P	C permission to leave all X-ray,	appointments, lab results and other me	dical information and advice
on (check all that apply)			
	nswering machine at home	☐ Cell phone	
\square Okay to leave message with fam		nember's name:	
☐ Do not leave a message	_	/ phone number	
Relationship to Patient:	☐ Parent	□Guardian	
ACKNOWLEDGEMENT OF NOTICE OF PRIVACE	Y PRACTICES		
Name of Patient (please print)			
Date of Birth:			
I hereby acknowledge that I am a	ware of Littleton Internal Medicine	e Associates' Notice of Privacy form which w	as offered to me.
Signature of Patient or Patient Representative	·	Date	