GRAYHAWK FAMILY PRACTICE

Patient Information (Please complete one per member)

Last Name:*	Legal First Name:*	M.I.:
Nickname:	Gender (M/F):*	
Address:*	Apt #:	
City:*	State:*	Zip:*
Employer:		
Birth Date (mm/dd/yr):*	Social Security Number:*	
Email:*		
Phone (mobile):	Phone (home):	Phone (work):
Preferred phone (select one): ☐ Mobile ☐ Home ☐ Work		

☐ It is ok to use this email address to send notices related to appointments, emails from my doctor and lab results. (Note: Emails may contain personal identifiable information, such as name, date of birth and home address.

☐ It is ok to send text messages to my mobile phone (e.g., for appointment reminders)

☐ I want access to the Health Portal – where I can email my physician, view medical records, lab results, and more

Do you have Medicare as your primary insurance?* ☐ Yes ☐ No
Do you receive Medicaid or state-provided medical assistance?* ☐ Yes ☐ No
Do you (or an employer on your behalf) contribute to a Health Savings Account? ☐ Yes ☐ No

Patient Acknowledgments

By my signature below dated ____________________, 20____ (Effective Date), I hereby acknowledge that the following documents have been provided and/or made available to me and I agree to the following statements relating to such documents:

Grayhawk Family Practice Membership Agreement

By signing below, I agree to be bound by the terms of the Membership Agreement (attached hereto) including the Detailed Service List.

Grayhawk Family Practice Notice of Privacy Practices

The Grayhawk Family Practice Notice of Privacy Practices details how my personal health information may be used and disclosed as permitted under federal and state law. By signing below, I acknowledge that I understand and accept the contents of the Notice.

Grayhawk Family Practice Terms and Conditions

I understand that the Grayhawk Family Practice Terms and Conditions are an essential and integral part of this Membership Agreement. By signing below, I acknowledge that (i) the Grayhawk Family Practice Terms and Conditions have been made available to me and (ii) I have read and understand the Grayhawk Family Practice Terms and Conditions including the disclosures contained therein.

By agreeing to these policies, I am agreeing for myself and for all enrolled dependents under age 18 for whom I am the legal parent, guardian or personal representative.

____   ____

Signature of Patient or Legal Guardian   Patient Name