

New Patient Information
Art of Medicine, P.A.
Eduardo J. Balbona, M.D. - Internal Medicine

Patient's First Name	M.I.	Patient's Last Name	
Date of Birth (mm/dd/yyyy)	Gender	Social Security Number	
Street Address	City	State	Zip Code
Home Telephone	Alternate Telephone & Email* (*optional)		

Guarantor / Insured

First Name	M.I.	Last Name	
Street	City	State	Zip Code
Home Telephone	Relationship to Patient		
Insured Date of Birth	Insured SSN		

Employer of Guarantor / Insured

Company Name	Title/Occupation
Work Telephone	Status: Full-time, Part-time or Retired

Employer of Patient

Company Name	Title/Occupation
Work Telephone	Status: Full-time, Part-time or Retired

Your Personal Information:

- You have the right to inspect and copy your own protected health information.
- You have the right to request restrictions on the use and disclosure of your protected personal health information.
- You have the right to request an amendment to your protected health information.
- You have the right to receive an accounting of certain disclosures, in any have occurred, of protected health information.

Acknowledgement of Receipt of Notice of Privacy Practices:

We are required by law to provide a written Notice of our Privacy Practices.
Please sign below to acknowledge your receipt of this printed information.

Signature of Patient: _____

Date: _____