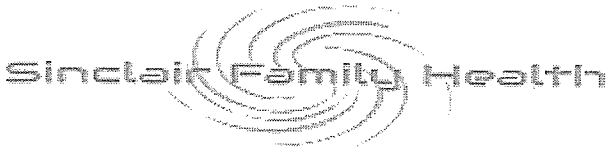


Name:_____ Date of Birth:_____

Address:_____

Home Phone:_____ Cell:_____

Email:_____ S.S.#_____

Sex:_____ Marital Status:_____

Employer:_____ Spouse Employer:_____

Spouse Name:_____ Spouse Work Phone:_____

Pharmacy:_____

If Minor, Please Complete

Mother's Name:_____ Address:_____

S.S. #_____ Work Phone:_____

Father's Name:_____ Address:_____

S.S. #_____ Work Phone:_____

Insurance Information

Primary Insurance:_____ Name of Insured:_____

Date of Birth:_____ Insured's S.S. #_____

Relationship to Insured:_____

Secondary Insurance:_____ Name of Insured:_____

Date of Birth:_____ Insured's S.S. #_____

Relationship to Insured:_____

Emergency Contact:_____ Relationship:_____

Address:_____

Phone:_____

Name of other physicians who care for you:_____

I authorize any holder of medical or other information about me to release to my insurance company or to the social security administration and health care financing administration or its intermediaries or carrier any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party whom accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:_____ Date:_____

Sinclair Family Health

Patient Name: _____

Medication: _____

_____

_____

Medical Problems: _____

_____

_____

Drug Allergies/Reaction: _____

Surgeries/Date: _____

_____

Family History:

Dad-year of birth- living or deceased

Health history:

Mom- year of birth-living or deceased

Health history:

Siblings-year of birth- (list all and include health history)

Social History:

Smoke- current, former, or never If quit, when?

How many and Frequency?

Drink Alcohol- yes or no

How many/how often?

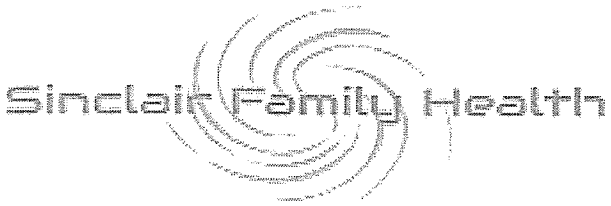
Sinclair Family Health

No Show Consent

At Sinclair Family Health we strive to provide timely healthcare to all of our patients. It is important that you notify us at least 24 hours in advance if you are unable to keep your scheduled appointment so that we are able to schedule an appointment for someone else. Failure to notify us that you are unable to keep your appointment will result in a no show fee.

_____ _____

Signature Date



Summary of Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information (PHI). I understand that this information will be used to:

1) Direct my treatment and follow up possibly among multiple healthcare provider who may be involved in my treatment both directly and indirectly.
2) Obtain payment for services rendered.
3) Conduct normal practice of operations.

I understand that I also have rights with respect to my protected health information:

1) The right to inspect and copy my information
2) The right to amend my information
3) The right to an accounting of my disclosures
4) The right to request restriction to those disclosures
5) The right to confidential communications
6) The right to file a complaint if I feel my rights have been violated

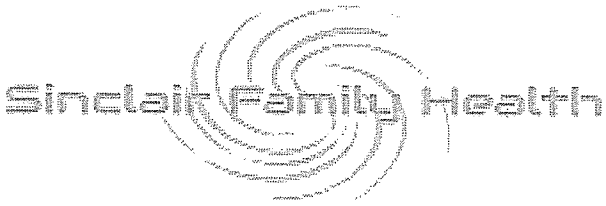
I have been informed of SFH's Notice of Privacy Practices, understand that this is a summary of those practices and have had time to review the entire Notice of Privacy Practices prior to signing this summary. I also understand that I can request a copy of the Notice of Privacy Practices at any time. I understand that SFH has the right to change its privacy practices and will post any changes.

_____ _____

Patient Signature Date

_____

Date of Birth



Consent for Use and Disclosure of Protected Health Information

With my consent, SFH may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to SFH's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. SFH reserves the right to revise its Notice of Privacy Practices at any time.

With my consent, SFH may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, SFH may mail to my home or other designated location any items that assist the practice in carrying out TPO. Such as appointment reminder cards and patient statements.

I have the right to request that SFH restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to SFH's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, SFH may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient Name