HATBORO
MEDICAL ASSOCIATES

345 N. York Road
Hatboro, PA 19040
215-675-1516

Full Name: _____ Date of Birth _____

Address: _____

Phone Number: Best Contact# _____ Alt# _____

OK to Leave Message: ☐ YES ☐ NO (answer machine must be identified)

Birth Sex: ☐ Male ☐ Female Gender: Male (He/His) Female (She/Her) Non-Binary (They/Them)

Marital Status (circle): Single Married Divorced Widowed Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refused

Race: ☐ White ☐ Black/ African American ☐ American Indian ☐ Asian ☐ Other ☐ Decline to report

Language: _____ Interpreter Services Needed: YES ☐ NO ☐

*Email_____ Register for our Patient Portal YES ☐ NO ☐

Emergency Contact Information:

Name _____ Relationship _____ Phone_____

Advance Directive/Living Will: ☐ Yes ☐ NO

Pharmacy Information:

Pharmacy Name _____ Phone _____

Pharmacy Address _____

Primary Insurance

Name of Insurance _____ Member ID Number: _____

Policy Holder and Date of Birth _____ Relationship to Patient _____

Secondary (Supplemental) Insurance

Name of Insurance _____ Member ID Number: _____

Policy Holder and Date of Birth _____ Relationship to Patient _____

HIPAA Consent: I understand my rights and authorize Hatboro Medical Associates to disclose individual information from my medical records with the following:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

(HMA Notice of Privacy Practices can be obtained at the Front Desk)

Signature: _____ Date: _____