PATIENT INFORMATION SHEET

NAME

LAST FIRST MIDDLE

ADDRESS | HOME PHONE ( )

WORK PHONE ( )

CITY | ZIP CODE | CELL PHONE ( )

DATE OF BIRTH | SOCIAL SECURITY #

PERSON TO CONTACT IN EMERGENCY | RELATIONSHIP | PHONE ( )

MARITAL STATUS (please circle) MINOR / SINGLE / MARRIED / DIVORCED / WIDOWED. | SEX MALE / FEMALE

EMPLOYER

PRIMARY CARE PHYSICIAN (AS SHOWN ON YOUR INSURANCE CARD)

REFFERING PHYSICIAN

ETHNICITY: PLEASE CIRCLE ONE: HISPANIC or LATINO NOT HISPANIC or LATINO NOT PROVIDED

RACE: [NOT PROVIDED] | LANGUAGE [NOT PROVIDED]

PLEASE COMPLETE INFORMATION FOR SPOUSE, OR FOR PARENT / LEGAL GUARDIAN IN CASE OF MINOR

LAST NAME | FIRST NAME

ADDRESS

DATE OF BIRTH | SOCIAL SECURITY NO.

EMPLOYER

PHONE: DAYTIME EVENING

PRIMARY INSURANCE

I.D.# | GROUP# | EFFECTIVE DATE

NAME OF INSURED | RELATIONSHIP TO PATIENT

SECONDARY INSURANCE

I.D.# | GROUP# | EFFECTIVE DATE

NAME OF INSURED | RELATIONSHIP TO PATIENT

PHARMACY | LAB

I authorize release of any information concerning my, (or my child's) health care, advice and treatment for the purpose of evaluation and administering claims for insurance benefits. I authorize payment of benefits, for any medical and surgical services rendered to me, to Stockton Hematology Oncology Medical Group. I understand I am responsible for all copayments at the time service is rendered to me.

SIGNED | DATE

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form.** For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

Patient Name
(First Name, Middle Initial, Last Name)

Email Address of Patient/Authorized User

Date of Birth of Patient

Physician's Name

Authorized User is:

☐ Patient
☐ Patient's Designee

Patient's Designee's Name (Printed)

Patient's Designee's Signature

Patient's Medical Record Number

☐ Declined

Patient's Signature

Date

Signature of Practice Staff
[confirming user's identity and authority]

Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose. Please make a copy for patient.

Staff Use Only:	MRN_____
Email in PMS or iKM_____	iKM Consent_____