Sunshine Medical Care

Required Demographic Information

Patient's Name: _____ DOB: _____

1. Race:
   ___ American Indian or Alaskan Native ___ Asian
   ___ Black or African American ___ White
   ___ Native Hawaiian or Other Pacific Island ___ Other Race (_____)

2. Ethnic Group:
   ___ Hispanic or Latino ___ Not Hispanic or Latino

3. Preferred Language: (_____)

4. Preferred Reminder Method:
   ___ Home phone ___ Home phone only
   ___ Cell phone ___ Cell phone only
   ___ Work phone ___ Work phone only

Medical Information Release Consent

I _____ give Sunshine Medical Care permission to release my medical information to:

1. _____ Relationship to patient_____
2. _____ Relationship to patient_____
3. _____ Relationship to patient_____

Do Dr. Barsoum and staff have permission to leave the following information on your answering machine or voicemail: Choose one: Home:_____ Cell: _____

Appointment Information: ____ Yes ____ No

Billing Information: ____ Yes ____ No

Medical Information (medication changes, lab results, radiology results)
____ Yes ____ No

This consent will remain in effect for seven (7) years unless revoked in writing

_____
Print Name

_____ _____
Patient Signature Date