

Name:		Phone number:	Birth date:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		City:	State:	Zip:	
Email:			Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Emergency contact name and number (optional):			Are you currently a student: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of school:		
Marital status: <input type="checkbox"/> Annulled <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Never Married / Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Widowed <input type="checkbox"/> Decline to Specify		Ethnicity: <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino Race (check all that apply): <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other, Specify: _____ <input type="checkbox"/> Decline to Specify		How did you hear about us? <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Internet (google, digital ad, etc.) <input type="checkbox"/> Social Media (Instagram, TikTok, Facebook) <input type="checkbox"/> Ames Fitness Center <input type="checkbox"/> The Daily Dose <input type="checkbox"/> Referral <input type="checkbox"/> School <input type="checkbox"/> Sign (Road Sign, Billboard, etc.) <input type="checkbox"/> Mobile Unit <input type="checkbox"/> Other, Specify: _____ <input type="checkbox"/> Decline to specify	
<p>If you do not wish to be called by Obria staff, please speak with a staff member. By signing below, you are agreeing to the terms outlined in the Email/Text Communication Information form. If you do not wish to receive specific forms of follow-up communication, please request below.</p> <p><input type="checkbox"/> Do NOT Text <input type="checkbox"/> Do NOT Leave voicemail <input type="checkbox"/> Do NOT Email</p>					
<p>I give Obria staff permission to identify themselves as staff of Obria Medical Clinic when contacting me.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>I verify that I have received a copy of Obria Medical Clinic’s Notice of Privacy Practices and reviewed the Use and Disclosure of Protected Health Information consent form. I give my permission to Obria Medical Clinics to use and disclose my health information in accordance with the Notice of Privacy Practices and State and Federal Rules and Regulations of Health Insurance Portability and Accountability Act. I also verify that the information on this form is accurate to the best of my knowledge.</p>					
Signature _____			Date _____		