

Patient Information	Referred By:
Last Name: _____ <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Other _____ Sex: Male _____ Female _____	
First Name: _____ Date of Birth: ___/___/___ Age _____ SSN: _____-_____-____	
Middle Name: _____ Preferred Name: _____ Primary Language: _____	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or OPI <input type="checkbox"/> White	
Student Status: <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> N/A School: _____ Employment: <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> N/A Employer: _____	
Address: _____ City: _____ County _____ State: _____ Zip: _____	
Email Address: _____	
Phone: Home () _____ Work () _____ Cell: () _____	
May we leave a voice message to remind you about appointments at your home or cell phone number? Yes _____ No _____	
May we leave a voice message for normal test results at your home or cell phone number? Yes _____ No _____	
(Complete <u>only</u> if you want the Practice to contact you at an address/phone different than you gave above)	
Other Address: _____ City: _____ State: _____ Zip: _____ Other Phone () _____	
Pharmacy Name and Phone Number: _____	
Emergency Contact Name _____	
Relationship _____ Home Phone () _____ Work Phone () _____	

Guarantor/Responsible Person (if different from patient)
Last Name: _____ <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Other _____ Sex: Male _____ Female _____
First Name: _____ Date of Birth: ___/___/___ Age _____ SSN: _____-_____-____
Middle: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home () _____ Work () _____ Cell: () _____
Guarantor Email Address: _____

<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Insurance Company: _____	Insurance Company: _____
Policyholder Name: _____	Policyholder Name: _____
Member or Policyholder ID#: _____	Member or Policyholder ID#: _____
Policy Holder Date of Birth: _____	Policy Holder Date of Birth: _____
Insurance Co. Phone Number: (____) _____	Insurance Co. Phone Number: (____) _____
Group # _____	Group # _____
Insurance Co. Address: _____	Insurance Co. Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____

Ongoing Communication Regarding Your Healthcare

We may release/discuss your health information with the following people or organizations for the following dates of service, range of time, or event(s):

From (MM/DD/YY) _____ To (MM/DD/YY) _____

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate Authorization to Release Information Form must be completed if the information being released is different for these people or organizations listed above.

Authorization, Assignment of Benefits, and Referral Medical Release

I allow this Practice to use and release my protected health information for treatment, payment and healthcare operations as allowed by HIPAA and as described in the Roper St. Francis Healthcare Notice of Information Practices. I have been provided a copy of the Roper St. Francis Healthcare Notice of Information Practices.

I allow the release of medical information including complete medical records, test results, and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment.

I request the following restrictions on the use of my information: _____

I allow payment made directly to Roper St. Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this practice and my physician informed of changes to any of my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: _____

Patient Signature: _____

Date ____ / ____ / ____

Print Guardian's Name: _____

Guardian Signature: _____

Date ____ / ____ / ____

Office Use Only: