CONFIDENTIAL PATIENT INFORMATION

PATIENT DEMOGRAPHICS

Prefix
○ Mr. ○ Mrs. ○ Miss ○ Ms.

Last Name ______________ First Name ______________ Middle Initial ______

Preferred Name to be called ______________

Social Security ____-_____-_____

Birth Date ___/___/_____

Gender (select one) ○ Male ○Female

Mailing Address ______________ City / State ______________ Appt/Lot/Space # ______ Zip Code ______

Race (Select one or more)
○ White
○ Hispanic or Latino
○ Black or African American
○ Asian
○American Indian / Alaska Native
○ Native Hawaiian or Other Pacific Islander
○Unknown / Not reported

Ethnicity
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Unknown / Not Reported

Preferred Language ______________

May we leave you a phone message? Y / N
Preferred Method of Contact (Indicate One below)
○ Cell ○ Home ○ Work ○ Mail ○ Email

Marital Status (Select One) ○ Married ○ Partner ○ Separated ○ Divorced ○ Single ○ Widow

Primary Care Physician (First and Last Name) ______________

Referring Physician (First and Last Name) ______________

Your Home Telephone # ______________ Your Work Telephone # ______________

Your Cell Telephone # ______________ Your E-Mail Address ______________

Employment Status (Select One) ○ Part-time ○ Full-time ○ Retired ○ Other

Employer Name ______________ Employer Telephone # ______________ Job Title ______________

Name of your Emergency Contact ______________ Relationship ______________ Telephone # ______________

INSURANCE POLICY INFORMATION

Primary Insurance ______________ Policy Holder's Name ______________

Policy Holder's Date of Birth ____/_____/______ Name as it appears on card ______________

Policy # ______________ Group # ______________ Effective Date ______________

Secondary Insurance ______________ Policy Holder's Name ______________

Policy Holder's Date of Birth ____/_____/______ Name as it appears on card ______________

Policy # ______________ Group # ______________ Effective Date ______________

PHARMACY INFORMATION

CONFIDENTIAL PATIENT INFORMATION

May we have your consent to prescribe Electronically? ○ Yes ○No

Pharmacy Name ______________________________ Location ______________________________

ADVANCE DIRECTIVE *Do you have one? if yes complete information below if no check box* □

□ Do Not Resuscitate (DNR) □ Surrogate Decision Maker *(heath care provider)* □ Non Surrogate Decision Maker

GENERAL CONSENT

The information presented here enables you to consent for needed medical care services, as well as for the release of information from your medical records for medical and administrative purposes.

HIPAA ACKNOWLEDGEMENT:

I hereby acknowledge that I have received/been offered a copy of the Boise Osteopathic Medical Clinic Notice of Privacy Practices on this date or on a previous date. **Initial** ____________

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS/PAYMENT AGREEMENT: All accounts are due and payable at the time of service unless other prior arrangements have been made. I understand that I am responsible for any and all balances owing. I hereby authorize payment directly to Boise Osteopathic Medical Clinic of all healthcare benefits, not to exceed charges, to which I would otherwise be entitled for these services. I understand and agree regardless of my personal ability to pay, that I am financially responsible to Boise Osteopathic Medical Clinic for charges not covered by my insurance carrier.

IT IS YOUR RESPONSIBILITY TO TELL US IN ADVANCE IF THERE ARE ANY SPECIAL REQUIREMENTS FOR YOUR INSURANCE/THIRD PARTY PAYER, e.g., PRE-AUTHORIZAION PROCEDURES

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND DO VOLUNTARILY AGREE TO ITS PROVISIONS.

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
Responsible Person & Relationship Witness

MEDICARE PATIENT'S ASSIGNMENT AUTHORIZATION (For Medicare Insured Patients Only)

I request that payment of authorized **Medicare/Medicare Replacement Plan** benefits be made on my behalf to Boise Osteopathic Medical Clinic for any services furnished to me by a provider of the group. I authorize any holder of medical information about me to be released to Medicare and its agents any information needed to determine these benefits or benefits for related services payable. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicate deductible, co-insurance or the 20% that Medicare does not pay, and for any non-covered services. My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

MEDIGAP OR OTHER SECONDARY INSURANCE AUTHORIZATION (For Medicare Insured Patients with a secondary ins)

I request that payment of authorization Medigap benefits be made either to me or on my behalf to Boise Osteopathic Medical Clinic for services provided to me by a physician/provider of the group. I authorize any holder of medical information about me to be released to my Medigap insurer or any information need to determine these benefits or the benefits payable for related services. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

______________________________ ______________________________
Signature Date