CONFIDENTIAL NON-MEDICARE 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

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 _____

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PHARMACY 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

AUTHORIZATION TO SHARE ACCOUNT RELATED INFORMATION

I hereby authorize BOISE OSTEOPATHIC MEDICAL CLINIC to disclose specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed: ◯ Medical Record
◯ Financial Information

Information to be given to:

Name:_____

Relationship:_____

This authorization shall remain in effect from the date signed below and until (please check one):

◯ _____ (specific expiration date or event)

◯ NO EXPIRATION DATE

_____ _____

Signature (& relationship to patient) Date