Clinic Demographics

Patient Legal Name: _____
Last **First** **Middle**

Date of Birth: _____ **Race:** _____ **Ethnicity:** _____ **SS#:** _____

Email address: _____ **I decline to give an email address:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

We want to personalize your care at Northern Medical Group so we are collecting data that helps us know how to provide the best care for you. Part of this process includes collecting sexual orientation and gender identity demographic information.
Would you be willing to disclose your sexual orientation and gender identity: ☐ Yes ☐ No

If no, skip this section:

Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

Gender Identity: ☐ Male ☐ Female ☐ Trans Female to Male ☐ Trans Male to Female ☐ Neither exclusively Male nor Female
☐ Other ☐ Gender Identity Comment:_____

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Don't know
☐ Decline to Answer ☐ Other:_____

I understand that I am responsible for any charges in full at time of visit if I do not have insurance. I am responsible to pay the co pay or deductibles at the time of my visit. I further understand that I am responsible for any charges that are NOT a covered service with my insurance plan. I understand that an insurance card presented is not a guarantee of payment.

I give permission to treat and to send information to my referring physician and referred physician if deemed necessary by my physician.

I give the names listed below permission to discuss my treatment, pick up prescriptions and pick up any forms.

_____

_____

I understand that I may revoke this authorization at any time by presenting a request for revocation in writing to a Health Information Department; however, a revocation will not reverse any action already taken in reliance upon this Authorization.
I also understand that the information disclosed pursuant to the authorization may include information concerning patient's mental health, use or treatment concerning drugs and/or alcohol, HIV/AIDS and/or other communicable diseases and/or genetic testing results.

I give permission to retrieve my medication history through the Surescripts Electronic Prescription Network.

I understand that I have the right to request restrictions concerning the use of my information. Below are those restrictions:

_____

Patient or Guardian Signature: _____ **Time:** _____ **Date:** _____

Witness Signature: _____ **Time:** _____ **Date:** _____

NORTHERN REGIONAL HOSPITAL

Clinic Demographics

Name:
Acct #:
Unit #:
Adm Date:
Room: DOB:
Physician:

CNETDEM CNET01 032323