Clinic Demographics

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

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

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

Patient's Address: _____

City: _____ **State:** _____ **Zip:** _____

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

Birth Sex ☐ Male ☐ Female ☐ Decline to answer

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:** _____
