Patient Identification

Last Name: ______________________________ ☐ Mr. ☐Mrs. ☐ Miss SSN: _______-_____-________

First Name: ______________________________ Other title ______________________ Date of Birth: ____/____/______

Middle: ______________________________ *(Doctor, General, the III, etc…)* Sex: Male _____ Female _____

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed Relationship to Guarantor: ____________________

Student Status: ☐Full ☐Part ☐N/A School: _____________________________ Phone: ( ) ____________________

Employment: ☐Full ☐Part ☐None Employer: __________________________ Phone: ( ) ____________________

Address: (**This practice will send all correspondence to this address unless you provide us an alternate address below**)

Street: ____ City: ____________________ State: ________ Zip: ____________

Phone: ( ) __________________ (**RSFH will contact you at this number unless you provide us an alternate number below)**

May we leave a general voice message for appointment reminders at this contact phone number? Yes _________ No _________

May we leave a general voice message for normal test results at this contact phone number? Yes _______ No _________

In Case of Emergency Contact Name ____

Relationship____________________________ Home Phone ( )________________ Work Phone ( )________________

Guarantor/Responsible Party (if different from patient)

Last Name: ____________________________ ☐ Mr. ☐Mrs. ☐ Miss SSN: _______-_____-________

First Name: ____________________________ Other title ______________________ Date of Birth: ____/____/______

Middle: ____________________________ *(Doctor, General, the III, etc…)* Sex: Male _____ Female _____

Address: ____ Phone: Home ( ) ______________________

City: __________________________ State: ________ Zip: _______________ Phone: Work ( ) ______________________

(Complete only if you want the Practice to communicate with you at an address/phone different than you provided above)

Alternate Address: ____ **Alternate Phone: ( )** ______________________

City: _____________________________ **State:** __________ **Zip:** ______________

Primary Insurance | Secondary Insurance

Primary Insurance			Secondary Insurance		
Member/Policyholder (if different from patient)			Member/Policyholder (if different from patient)		
____________________			____________________		
Member/Policyholder ID#	Date of Birth		Member/Policyholder ID#	Date of Birth	
____________	____________		____________	____________	
Insurance Co. Phone Number	Group #		Insurance Co. Phone Number	Group #	
(_____)______________	____________		(_____)______________	____________	
Insurance Co. Address (Street Address/ P.O. Box)			Insurance Co. Address (Street Address/ P.O. Box)		
____________________			____________________		
City	State	Zip	City	State	Zip
____________	______	______	____________	______	______

Ongoing Communication Regarding Your Healthcare

We may release/discuss your health information with following individuals/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 must be completed if the information being release differs between the individuals/organizations listed above.

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize 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 understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Roper Saint 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 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.

I have been provided a copy of the Roper Saint Francis Healthcare Notice of Information Practices.

Signed: ____ Date _________/__________/__________

Office Use Only:

Referred by: ______________________________