ST. ELIZABETH AFTER HOURS

Patient Information Sheet

MRN (Epic) _____ **Patient Information**

Name _____ Social Security # _____ Sex: M F
Last First Middle

Date of Birth _____ other known name(s) _____

Mailing Address _____ _____ _____ _____
City State Zip

County _____ Country _____ □ permanent address □ temporary address

Home phone _____ Work phone _____ Mobile phone _____

Email address _____ Language _____

Person outside of household to contact in case of emergency or in case we must reschedule an appointment for you.

Name _____ Phone #'s _____ Relationship _____

Marital Status: (circle one)
Married
Legally Separated
Widowed
Unknown
Divorced
Single
Significant Other
Other

Ethnicity: (circle one)
Hispanic or Latino
Not Hispanic or Latino
Unknown
No Answer

Race: (circle one)
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White or Caucasian

Primary Care Physician_____

Responsible Party Information (Guarantor)

Name _____ Social Security # _____ Sex: M F
Last First Middle

Date of Birth _____ other known name(s) _____

Mailing Address _____ _____ _____ _____
City State Zip

County _____ Country _____ Relationship to patient _____

Home phone _____ Work phone _____ Mobile phone _____

Employer _____

Employer address _____ _____ _____ _____
City State Zip

Employer phone _____ Employer fax _____

Employment Status: (circle one) disabled full time part time not employed on active military duty retired Self-employed student full-time student part-time unknown

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

Signed_____ Date _____ Witness _____

I specifically allow the following persons access to my protected medical information and to my medical and billing records:

_____

Subscriber Information (if different from Guarantor)

Name _____ Social Security # _____ Sex: M F
Last First Middle

Date of Birth _____ other known name(s) _____

Mailing Address _____ _____ _____ _____
City State Zip

County _____ Country _____ Relationship to patient_____

Home phone _____ Work phone _____ Mobile phone _____

Employer _____

Employer address _____ _____ _____ _____
City State Zip

Employer phone _____ Employer fax _____

Employment Status: (circle one) disabled full time part time not employed on active military duty retired
Self-employed student full-time student part-time unknown

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Insurance Information

(Primary Coverage)

Insurance Company _____

Ins Address _____

City _____ State _____

Zip _____ Phone _____

Relationship to Patient _____

Insurance ID # _____

Effective Date _____

Group # _____

Name on Card _____

Covered Through: (circle one) current employer retirement
Cobra/continuation of benefits
Other _____

Employer Size: (circle one) 1-19 employees
20-99 employees
100+ employees

(Secondary/Supplemental Coverage)

Insurance Company _____

Insurance Address _____

City _____ State _____

Zip _____ Phone _____

Relationship to Patient _____

Insurance ID# _____

Effective Date _____

Group # _____

Name on Card _____

Covered Through: (circle one) current employer retirement
Cobra/continuation of benefits
Other _____

Employer Size: (circle one) 1-19 employees
20-99 employees
100+employees

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I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.
I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many healthcare professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.
I understand that I have the right to object to the use of my health information for directory purposes, to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested and to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signed_____ Date _____