PRIME HealthCare, PC

PATIENT INFORMATION FORM

www.primehc.com

Patient Name

SEX
☐ Female
☐ Male

Answers to Questions Below ARE Required by the Federal Government American Recovery & Reinvestment Act of 2009

Social Security #

Date of Birth

Marital Status
☐ S
☐ M
☐ D
☐ W

Email Address

Race
☐ Caucasian
☐ Black
☐ Asian
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Other Race
☐ Unknown

Ethnicity
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Ethnicity
☐ Caucasian
☐ Other
☐ Unknown

Language
☐ English
☐ Spanish
☐ French
☐ Polish
☐ Vietnamese
☐ Sign
☐ Other

Employment Status
☐ Employed ☐ Retired ☐ Part-Time Student ☐ Full-Time Student
☐ Self-Employed ☐ Disabled ☐ Unemployed

Mailing Address City State Zip Code

Home # Mobile # Work # & Extension

Employer Employer Address City State Zip Code

Referring Physician

Primary Care Physician

Referral Source
☐ Specialist ☐ PCP
☐ Physical Therapist ☐ Walk-In
☐ SFH-ER ☐ HH-ER
☐ Patient ☐ Friend
☐ Radio Ad ☐ TV Ad
☐ Yellow Pages ☐ Internet
☐ Educational Series ☐ Website
☐ Newspaper/Magazine Ad
☐ Marketing Campaign
☐ Other _____

Primary Insurance Plan Name

Group #

Effective Date

Insurance ID#

Visit Copay $ Amount

Deductible $ Amount

Subscriber: ☐ Patient ☐ Parent ☐ Spouse ☐ Other _____

Subscriber Name _____ DOB: _____

Social Security # Employer

Secondary/Supplemental Insurance Plan Name

Group #

Effective Date

Insurance ID#

Visit Copay $ Amount

Deductible $ Amount

Subscriber: ☐ Patient ☐ Parent ☐ Spouse ☐ Other _____

Subscriber Name _____ DOB: _____

Social Security # Employer

Emergency Contact

Relationship to Patient: ☐ Wife ☐ Husband ☐ Child ☐ Parent ☐ Friend ☐ Guardian ☐ Other _____

Name (F/M/L) Contact Phone # Work Phone #

I hereby authorize direct payment of medical/surgical benefits to PRIME Healthcare, PC for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I hereby authorize PRIME Healthcare, PC, its agents and representatives, to access information regarding my person, whereabouts and medical history and to release all necessary information to my insurance company regarding my medical history, examinations, and treatment for the purposes of processing my insurance coverage. A photocopy of my signature is as valid as the original.

Signature _____ **Date** _____

PARENT / GUARDIAN INFORMATION

Patient's Relationship: ☐ Child ☐ Wife ☐ Husband ☐ Parent ☐ Brother/Sister ☐ Grandparent ☐ Aunt/Uncle ☐ Niece/Nephew ☐ Power of Attorney ☐ Other _____

Name (F/M/L) Social Security # DOB

Pharmacy Name/Address **Phone#**

PRIME HealthCare, PC

HIPAA PATIENT CALLING INFORMATION

Name: _____

Date of Birth: _____

With whom do you allow us to share your personal medical information?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

How may we contact you?

Pleas list in the order the way you wish to be contacted. (1-4)

____**Home Phone:** _____

- DO NOT leave a message
- Leave a brief message, return number
- May leave a detailed message

____**Work Phone:** _____

- DO NOT leave a message
- Leave a brief message, return number
- May leave a detailed message

____**Cell Phone:** _____

- DO NOT leave a message
- Leave a brief message, return number
- May leave a detailed message

**I understand that it is my responsibility to notify the office of any changes in my calling or HIPPA information.

Patient Signature _____ Date _____

PRIME HealthCare, PC

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: _____ Date of Birth: _____

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that it may be amended at any time, and that I may request a copy of the Notice of Privacy Practices at any time.

This policy is applicable to all offices within Prime Healthcare. I understand that if I have any questions or complaints, I may contact the Privacy Officer at (860) 263-0253 EXT 231

Signature: _____ Date: _____

If not signed by the patient, please indicate your relationship to the patient: _____

For Office Use Only:

- Signed form received by: _____
- Acknowledgement refused:

  Efforts to obtain: _____ Reasons for refusal: _____