Please Print Patient Demographic Form

MRN: Date:

PATIENT INFORMATION

Last Name: First Name: Middle Initial: Nickname (AKA):

Date of Birth: Social Security Number: ­Primary Phone Number:

Marital Status: Married Single Divorced Separated Widowed Other

­­Race: Black – American Indian/ Hispanic White/ Other

Non-Hispanic Alaskan Native Non- Hispanic

Home Address: Apt #: City: State: Zip Code:

Email Address:

**Employer**: **Work Phone Number:**

**Preferred method of contact:**  Cell Home Work Text

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Last Name: First Name: Relationship to the Patient: Primary Phone Number:

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Last Name: First Name: Relationship to the Patient: Primary Phone Number:

PRIMARY CARE INFORMATION

Primary Care Physician: Preferred Pharmacy:

PATIENT INSURANCE INFORMATION

Primary Insurance

Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Policy Holder’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance

Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Policy Holder’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient:  Self Parent Other

Last Name: First Name: Middle Initial:

Date of Birth: Social Security Number: ­ Primary Phone:

Home Address: Apt #: City: State: Zip Code:

­

Employment Status: Active-Duty Military Employed Full Time Employed Part-time  Not Employed  Student  Retired Stop outlineDisabled Homemaker  Self Employed

**Employer: Work Phone Number:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Initial** \_\_\_\_\_\_ I authorize the release of any information, including medical and billing information by Columbus Women’s (CWH) to my referring doctor or insurance company.

**Initial** \_\_\_\_\_\_ I authorize CWH to release my medical records to the Columbus Community Hospital Web Portal (HIE-Health Information Exchange)

**Initial** \_\_\_\_\_\_ I agree that CWH. may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers of third-party pharmacy benefit payers for treatment purposes.

**REQUEST TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION (PHI)**

The name(s) listed below are those to whom I wish to grant access to my healthcare information. I hereby authorize CWH to disclose my PHI including appointment and billing information to the following:

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do not wish to allow anyone to have access to my healthcare information.

I understand this consent will be considered valid for 1 year and will need to be updated annually. I also understand that this information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I understand and agree to these terms.

**FINANCIAL POLICY OF COLUMBUS WOMEN’S HEALTHCARE, P.C.**

**Initial** \_\_\_\_\_\_ I authorize payment of Medical Benefits, including Medicare and Medicaid benefits, be paid to CWH for services provided for my medical care. I understand it is my responsibility to know if my insurance coverage is In-Network or Out-of-Network with CWH and will be financially responsible for all charges accrued including any non-covered services, co-pays, co-insurance and deductible due after the final insurance payment has been paid to CWH. A final statement will be mailed to me, and I agree to pay that amount in full within 30 days of the date on the statement.

**NO-SHOW POLICY – COMMUNICATION AUTHORIZATION**

**Initial** \_\_\_\_\_\_ I authorize CWH to contact me via email, phone and/or text message. I acknowledge this may result in data charges and do not hold CWH responsible for those possible fees.

**Initial** \_\_\_\_\_\_ I am aware CWH will charge a $35.00 No-Show fee for any scheduled appointment that I fail to attend or cancel within 24-hour notice.

I have read each section above and initialed each appropriate section.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature or Person Authorized to Consent for Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date

*The following Columbus Women’s Health documents are available at patient’s request: Notice of Privacy Practices, Financial Policy, and Fee Schedules.*