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PATIENT DEMOGRAPHICS FORM

(Please Print)

Patient's full legal name FIRST________________MI ___ LAST __________________Maiden/Other____________

Date of Birth ____________________________**Soc Sec #** ________________________**Gender** _____

Mailing Address __________________________________ **City** ___________________ State ____ Zip ______

Home Phone ______________________ **Work Phone** ______________________**Cell Phone** ________________

E Mail _________________________________**Employer**___________________________ **Retired Y**____**N** ____

Student? Y __N ___Full time _____Part Time ___ **Married?** Y _ N __ **Preferred Language** ___________________

Race/Ethnicity (circle) Asian---Caucasian---Black/AfricanAmerican---Hispanic/Latino---American Indian/Alaska Native

Person responsible for billing: Name ______________________________ **Relationship:** _____________

Mailing address:__________________________City:___________________State:_____ Zip:_____Phone:____________

Insurance carrier __________________ **Policy Number** _________________ **Primary Care Provider**____________

Policy holder ________________________ □ **Father** □ **Mother** □ **Spouse** □ ____________**Birthdate** ____________

Emergency contact: Name ____________________________Relationship___________

Home phone_________________________ Work phone ______________________ Cell phone _________________

Acknowledgement and Signature for Release, Assignment, Financial Responsibility, and Privacy Notice:
I hereby give permission for the above patient to receive treatment which the attending medical practitioner considers necessary.
If insured, I authorize my insurance benefits be paid directly to Orcas Family Health Center and I will be responsible for any balance due not paid by my insurance and authorize the provider/insurance company to release any information required to process my medical claims.
If I do not have insurance, I understand that I am responsible for payment of all charges.
I agree with the financial policy and acknowledge receipt and Notice of Privacy Practices, describing how my health information may be used or disclosed.

Signature _________________________**Date** _________**Relationship** _____________**(i.e. self, mother, father, etc.)**

For office use:
Immunization Registry Status ___________________ **Immunization VFC Status** ____________________
Immune recall/reminder contact preference _____________________________
Entered Demos in Healthwind _____________________ **Entered Demos in Chart Connect** _____________________

Updated 11/2018 BR