PATIENT DEMOGRAPHIC SHEET

Thank you for completing this form, *our receptionist will assist you with all questions*. Your responses will be kept confidential.

PERSONAL INFORMATION

Today's Date: / /

	Date of Birth (mm/dd/yyyy):
Last Name:	Social Security Number:
First Name: Middle Initial:	Gender: ❑ Female ❑ Male
Previous Name:	Marital Status: ❑ Single ❑ Married ❑ Other_____
Mailing Address 1:	Spouse Name:
Street Address 2:	Employment Status: ❑ Full-time ❑ Part-time ❑ Not Employed
City:	❑ Active Military Duty ❑ Self-Employed ❑ Retired ❑ Unknown
State: Zip:	Employer Name:
Home Phone Number:	Student Status: ❑ Full-time ❑ Part-time ❑ Not a Student
❑ OK to leave a detailed message	**If you have an emergency or serious medical problem, who can we**
Cell Phone Number:	**contact?** *Please do not leave blank.*
❑ OK to leave a detailed message	Emergency Contact:
Work Phone Number:	Relationship:
❑ OK to leave a detailed message	Address:
Responsible Party:	City: State: Zip:
Relationship:	Phone:

Please list anyone with whom we may discuss your medical information:

INSURANCE/ FINANCIAL INFORMATION *(Please submit your insurance card(s) with this form for scanning.)*

Primary Insurance:		
Subscriber #:	Group #:	
Subscriber's Name:	Date of Birth:	Relation to patient:
Secondary Insurance:		
Subscriber #:	Group #:	
Subscriber's Name:	Date of Birth:	Relation to patient:

We offer a secured Patient Portal to access your Personal Medical Records, request appointments, and communicate with us over the internet. ***(Your email address will not be shared with anyone outside Bay Area Family Care)***

Register for Patient Portal: ❑ Yes ❑ No **Email address:**

Race: ❑ White ❑ Black/ Af. American ❑ American Indian ❑ Alaskan Native ❑ Asian ❑ Pacific Islander/ Hawaiian Native ❑ Other

Are you Hispanic? ❑ Yes ❑ No | Preferred Language: ❑ English ❑ Other | Interpreter needed? ❑ Yes ❑ No

PHARMACY

Primary Pharmacy Name:	
Address:	
Phone:	Fax:
Secondary Pharmacy Name:	
Address:	
Phone:	Fax:

By signing below, I acknowledge that the information I provided is accurate to the best of my ability.

Patient Signature: Date: / /

Patient Name: **Today's Date: / /**

FINANCIAL POLICY

We are committed to providing you with quality and affordable health care. Your clear understanding of our Financial Policy is important to our professional relationship. Our front desk receptionist and billing staff will be happy to assist in answering any further questions you may have. A copy will be provided to you upon request.

Insurance. We participate with Medicare, Blue Cross Blue Shield and several commercial insurance companies. You must provide our office with the necessary billing information for the visit. We will submit the charge on your behalf to your insurance. **You will be asked to provide us with your insurance card(s) at each visit.** Payment of all non-covered services and supplies will be requested at your service visit. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility.

Guarantee of Payment. All copays must be paid at the time of service. I hereby guarantee payment of all charges not paid by insurance, together with all necessary collection expenses. I understand that all bills are payable and become due upon presentation.

Nonpayment. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

Returned Check. A $25 charge will be applied to all returned checks.

Missed appointments. Appointments that are not cancelled at least 24 hour prior to the appointment will be considered a late cancellation. Our office does not charge for missed appointments, however *three* no show or late cancels appointments in a 12 month period could result in discharge from the practice. Please help us to serve you better by keeping your regularly scheduled appointment.

❑**INSURANCE PATIENTS** I hereby authorize *Bay Area Family Care* and its employees to release any/all medical information necessary to process claim(s) to my insurance carrier(s). I irrevocably authorize the insurance carrier(s) to assign all benefits/payments directly to *Bay Area Family Care* I understand that I am financially responsible for all charges whether or not my insurance covers those charges.

❑**MEDICARE PATIENTS:** I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to the provider. I further hereby authorize Medicare or their contracted carrier to furnish to the above named providers of service any information regarding my Medicare claims under Title XVII of the Social Security Act.

By signing below, I acknowledge that I have read and agreed to this Financial Policy.

_____ _____

Patient or Personal Representative Signature Date

RECORDS RELEASE

Notice of Privacy Practices. The Notice of Privacy Practices explains how *Bay Area Family Care* may use and disclose health information. By signing below, I acknowledge receipt of the Notice of Privacy Practices of *Bay Area Family Care*.

Prescription History Consent. By signing below, I give *Bay Area Family Care* permission to access a two year history of my medications for my care and treatment.

_____ _____

Patient or Personal Representative Signature Date

_____ _____

Name of Personal Representative Relationship