Patient Demographic

Have you been treated at any Saint Mary's Medical Group Clinics in the past 3 years: (Urgent Care, Primary Care, Specialist) ❑ **Yes** ❑ **No**

PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)		SOCIAL SECURITY NUMBER		DATE OF BIRTH	SEX ☐M ☐F
MAILING ADDRESS	APT/SUITE#	CITY	STATE	ZIP	
PHYSICAL ADDRESS (IF DIFFERENT)	APT/SUITE#	CITY	STATE	ZIP	
RACE	LANGUAGE	ETHNICITY	MARITAL STATUS		
HOME PHONE	CELL PHONE	EMAIL ADDRESS			
PRIMARY CARE PHYSICIAN	**PHONE NUMBER**	PREFERRED CONTACT NUMBER WHERE WE MAY LEAVE MESSAGES ABOUT YOUR HEALTHCARE? ☐**Home Phone** ☐**Work Phone** ☐**Cell Phone**			
EMPLOYER	WORK PHONE	EMPLOYEMENT STATUS ☐**RETIRED** ☐**FULL TIME** ☐**PART-TIME** ☐**UNEMPLOYED** ☐**STUDENT**			
EMPLOYER ADDRESS	SUITE#	CITY	STATE	ZIP	
EMERGENCY CONTACT (first name last name)		PHONE	DATE OF BIRTH	RELATIONSHIP	

How did you hear about us? ☐**Billboard** ☐**Radio** ☐**Insurance** ☐**Friend/ Friend** ☐**Drove By** ☐**Other** _____

☐**Referred By Physician**_____ phone _____

INSURANCE INFORMATION

PRIMARY INSURANCE

POLICY HOLDER NAME	RELATIONSHIP TO PATIENT ☐**Self** ☐**Spouse** ☐**Parent**	SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE
INSURANCE CARRIER	POLICY #	GROUP #	EMPLOYER	

SECONDARY INSURANCE

POLICY HOLDER NAME	RELATIONSHIP TO PATIENT ☐**Self** ☐**Spouse** ☐**Parent**	SOCIAL SECURITY NUMBER	DATE OF BIRTH	EFFECTIVE DATE
INSURANCE CARRIER	POLICY #	GROUP #	EMPLOYER	

Medicare Patients only: Are you entitled to Medicare because □**AGE** □ **DISABILITY** □ **ESRD**
Is someone else or another entity responsible for the billing claim from this visit? ☐ YES ☐ NO WHO_____

Are you here because of an injury? ☐ Yes ☐ No DATE OF INJURY__ __ / __ __ / __ __ __ __ ☐ Work ☐ Auto ☐ Other:

PARENT/GUARDIAN INFORMATION *(please fill out the section below for any child under the age 18)*

NAME (last, first)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX ☐M ☐F	
ADDRESS	CITY	STATE	ZIP	
RELATIONSHIP (check all that apply) ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Other** ☐ **Guarantor** (person financially responsible)	CELL PHONE	HOME PHONE	MARITAL STATUS	
NAME (last, first)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX ☐M ☐F	
ADDRESS	CITY	STATE	ZIP	
RELATIONSHIP (check all that apply) ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Other** ☐ **Guarantor** (person financially responsible)	CELL PHONE	HOME PHONE	MARITAL STATUS	

The information provided above is complete and accurate to the best of my knowledge. **Rev. 1.14.16 LE**

Patient/Guardian Signature_____ ***Date***_____

Saint Mary's Medical Group

Patient Demographics

PATIENT LABEL

PATIENT CONSENT & ACKNOWLEDGEMENT

PATIENT DOCUMENTS RECEIVED:

- Notice of Privacy Practices _____ (initial)
- Patient Financial Policy _____ (initial)
- Patient Portal Access and Use Agreement _____ (initial)

TREATMENT: I consent to and authorize Saint Mary's Medical Group and Saint Mary's Urgent Care Providers to examine and provide treatment.

RELEASE OF INFORMATION

- I authorize a copy of my record to be sent to my family provider or provider of referral following my appointment. **Preservation of Records Notice**: The Medical Group is authorized to dispose of patient's medical record after the 10th anniversary of the date the patient was last treated. For minor patients (less than 18 years of age) the medical group is authorized to dispose of patient's medical records after patient's 23rd birthday for those records which have been retained for at least 5 years or for any longer period provided by federal law.
- I authorize Saint Mary's Medical Group and Saint Mary's Urgent Care to speak to the named person (s) listed below regarding my medical condition(s) and care. Please be aware that we will not be able to speak to anyone other than the patient unless named below.

  Name _____ Relationship_____

  Name _____ Relationship _____

PRESCRIPTIONS: I authorize Saint Mary's Medical Group and Saint Mary's Urgent Care and its designees to view my pharmaceutical history from external sources. Our practice uses Surescripts for this purpose.

EMPLOYEE OR PROVIDER EXPOSURE TO BLOOD AND BODY FLUIDS: Patient understands that in the event an employee or provider is exposed to patient's blood or body fluids, a blood sample for HIV (AIDS), Hepatitis B and Hepatitis C antibodies will be obtained. Patient understands that the patient will be notified of testing. Patient understands that the results are confidential and will not be released to a third party without patient's permission except as permitted or required by law

INTERPRETER INFORMATION: If the patient speaks a language other than English or is communicatively disabled, I have accurately and completely read the forgoing documents to _____ (name of patient/person legally authorized to give consent) in the patient's or patient's representative primary language. He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing this document in my presence.

_____ _____

(SMMG Representative Name) *(SMMG Representative Signature)*

_____ _____ _____ *AM / PM*

(Cyracom ID number or Signature of onsite Interpreter) *(Date)* *(Time)*

By signing below, I agree to abide by the terms and conditions outlined above including the patient documents received.

Patient/Representative Name (Please Print) _____ Date _______________

Patient/Representative Signature _____ Date _______________

Saint Mary's Medical Group

Patient Consent and Acknowledgement

PATIENT LABEL