St.Vincent | ASCENSION

Patient Demographic Information Form

Please fill out every space. If it does not pertain to you, please write N/A. for Not Applicable.

Patient Information

Patient's Name (Last, First, Middle) (Suffix) (Preferred) (Former Last Name)

If patient is a minor, list names/contact info of Parents (step)/Guardians
(Last, First, Middle Initial) (Address) (Phone) (Relationship)

_____

_____

_____

_____

Sex ❑ Male ❑ Female

Date of Birth

Social Security #

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated ❑ Partner

Address **City** **State** **Zip code**

Home Phone **Mobile Phone** **Work Phone**

Patient Email

Preferred Languag e **Race**

Ethnicity ❑ Hispanic ❑ Non-Hispanic

Provider Information

Primary Care Physician / Phone Number **Referring Provider / Phone Number**

Communication

❑ I authorize St.Vincent, and those parties acting on behalf of St.Vincent, to contact me about appointments and reminders for health services via: ❑ Home Phone ❑ Mobile Phone ❑ Email

Is it OK to leave medical information on your answering machine or voice mail? ❑ Yes ❑ No

Patient Photos – (Photos may or may not be part of your patient care)

I _____DO or _____DO NOT give consent for photos to be taken of me for identification and/or treatment purposes. _____(*Patient/Parent/Guardian Initials*)

Emergency Contact Information

Name **Relationship**

Home Phone # **Mobile Phone #**

Employment

Employer's name **Phone**

Address **City** **State** **Zip code**

Guarantor (Name to Whom Statements are Sent)

Patient's Relationship to Guarantor			
Name (Last, First, Middle, Suffix)		**Date of Birth**	
Address	**City**	**State**	**Zip code**
Employer		**Social Security #**	

Insurance

Primary Insurance Company		**Subscriber's Name (Policyholder)**
Subscriber's DOB	**Subscriber's Social Security #**	**Relationship to Subscriber**
Secondary Insurance Company		**Subscriber's Name (Policyholder)**
Subscriber's DOB	**Subscriber's Social Security #**	**Relationship to Subscriber**

Clinical Information

Preferred Pharmacy
Preferred Lab

Financial and Treatment Consent

By signing my name below:

- I hereby guarantee payment in full within thirty (30) days of all charges established by St.Vincent Health for services rendered to me or my dependent, unless other arrangements satisfactory to St.Vincent Health have been made. This includes any charges that a third-party payer may determine to exceed usual and customary limits.
- I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collection, I will be responsible for paying attorney fees, interest, court costs, and other costs of collection, including but not limited to collection agency fees.
- I authorize Medicare, Medicaid, all relevant commercial payers to pay St.Vincent Health on my behalf for any services furnished to me or my dependent. I certify that I have read this assignment of benefits, that the information given by me is correct, and that I agree to all of the provisions contained in it.
- I understand that if I am facing financial difficulty I can apply for financial assistance from St.Vincent Health.
- The insurance information I have provided is current and correct. If I sign this form and the insurance card is found later to be outdated or invalid, I understand that I am responsible for paying for the services in full and will need to file with the insurance carrier myself.
- I hereby consent to treatment by my St.Vincent Health Provider(s). I understand that St.Vincent Health will release to my referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continuing care and as needed to process claims and for general health care operations. I agree that this Consent is valid for all treatment and payment of said treatment for a period of twelve (12) months following execution of the Consent.
- I understand my insurance co-pay is due at the time of service, per my insurance company policy.
- I acknowledge that I may receive a referral to a health care provider who does not contract with my health insurance company or participate in my insurance plan's network (an "Out of Network Provider") and that different coverage and payment limitations may apply to Out of Network Providers. I understand that I may contact my health insurance company for assistance, including identification of health care providers currently in my insurance plan's network, prior to obtaining items and services from an Out of Network Provider.

I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES : _____ (Patient's Initials)

_____ _____

Patient/Guarantor/Guardian Signature Date

OFFICE USE ONLY NPP Witness/Issued by: _____