PRIME HealthCare, PC

Patient Demographic Form

www.primehc.com

Patient Last Name	Patient First Name	MI	Date of Birth	SEX ☐Female ☐Male ☐Other: _____
Social Security #	Email Address			Marital Status ☐S ☐M ☐D ☐W

Employment Status: ☐Employed ☐Retired ☐Self-Employed ☐Part-Time Student ☐Full-Time Student ☐Disabled ☐Unemployed

The Federal Government asks providers to ask the questions below.

Race	Ethnicity	Language
☐Caucasian ☐Black ☐Asian ☐Native Indian / Native Alaskan ☐Native Hawaiian / Pacific Islander ☐Other Race ☐Unknown	☐Hispanic/Latino ☐Not Hispanic/Latino ☐Caucasian ☐Other ☐Unknown	☐English ☐Spanish ☐French ☐Polish ☐Vietnamese ☐Sign ☐Other

Home Address	City	State	Zip Code
Billing / Mailing Address	City	State	Zip Code

Preferred Phone: ☐Home ☐Cell ☐Work Leave detailed message?: ☐Yes ☐No	Additional Phone: ☐Home ☐Cell ☐Work Leave detailed message?: ☐Yes ☐No	Additional Phone: ☐Home ☐Cell ☐Work Leave detailed message?: ☐Yes ☐No

Employer	Employer Address	City	State	Zip Code

Primary Care Provider:	**Referring Physician:**	**Ophthalmologist:**
Primary Insurance Coverage Name	Insurance ID #: _____ Group #: _____	Effective Date: _____
Subscriber: ☐Patient ☐Spouse ☐Parent ☐Other Subscriber Name:	Date of Birth: _____ Social Security #: _____	Employer:
Secondary Insurance Coverage Name	Insurance ID #: _____ Group #: _____	Effective Date: _____ Copay $: _____ Deductible: _____
Subscriber: ☐Patient ☐Spouse ☐Parent ☐Other Subscriber Name:	Date of Birth: _____ Social Security #: _____	Employer:

Emergency Contact	Relationship to Patient: ☐Wife ☐Husband ☐Child ☐Parent ☐Friend ☐Guardian ☐Other
	Name: Contact Phone: W ork Phone:

I hereby authorize direct payment to medical/surgical benefitsto Prime Healthcare, PC for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me above is correct. I hereby authorize Prime Healthcare, PC, its agents and representatives,to access information regarding my person, whereabouts, and to release all necessary information to my insurance company regarding my medical history, examinations, and treatments for the purposes of processing my insurance claims. A photocopy of my signature is valid as the original.

Signature: _____ Date: _____

PARENT / GUARDIAN INFORMATION

Relationship to Patient: ☐Parent ☐Guardian ☐Brother/Sister ☐Power of Attorney ☐Other

Name:	Social Security #:	Date of Birth:	Contact #:

PHARMACY NAME/ADDRESS: **Phone Number:**

REV 9/19

PRIME HealthCare, PC

HIPAA PATIENT CALLING INFORMATION

Name:_____ Date of Birth:_____

With whom do you allow us to share your personal medical information?

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

How may we contact you?

Please list in the order the way you wish to be contacted. (1-3)

____ **Home Phone**:_____

_____ DO NOT leave a message
_____ Leave brief message, return#
_____ May leave a detailed message

____ **Work Phone**:_____

_____ DO NOT leave a message
_____ Leave brief message, return #
_____ May leave a detailed message

____ **Cell Phone:**_____

_____ DO NOT leave a message
_____ Leave brief message, return#
_____ May leave a detailed message

If you would like to communicate with our office via email, we encourage you to sign up for MyCare. This is a secure web portal. You can do this by going to www.stfranciscare.org/mycare . There is also an app on Googleplay or the App Store called My Chart.

**I understand that it is my responsibility to notify the office of any changes in my calling or HIPAA communication information.

PATIENT SIGNATURE_____ **DATE**_____

PRIME HealthCare, PC

Acknowledgement of Receipt of Privacy Practices

Name of Patient: _____ Date of Birth: _____

I hereby acknowledge that I was offered and/or reviewed a copy of Prime Healthcare's Notice of Privacy Practices. I understand that a copy of the current Notice of Privacy Practice's will be posted in the reception area, and is available online at www.primehc.com/patient-forms. I know that I may request a copy at any time.

I acknowledge that Prime Healthcare utilizes an electronic medical record that is affiliated with Saint Francis Hospital/Trinity of New England and its affiliates. Use and/or disclosure of my protected health information by Prime Healthcare PC or its affiliates will be for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information will be used or disclosed in accordance with Connecticut and Federal law, which may require me to provide specific authorization. Complete details are listed in our Notice of Privacy Practices.

This policy if applicable to all offices within Prime Healthcare. I understand that I may contact the Privacy Officer at 860-263-0253 if I have any questions or concerns.

Signature:

_____ Date:

If not signed by the patient, please indicate your releationsthip to the patient: _____

For Office Use Only:

__ Received
__ Acknowledged Refused

I made a good faith effort to obtain a written acknowledgement of the receipt of Notice of Privacy Practices from the above-named patient, but was unable to because:
Efforts to Obtain:

___ Individual refused
___ Emergency treatment situation
___ Individual not able to sign due to medical reasons
___ Other: _____

Name and Title of Employee

_____ Date: