



New Patient Demographic Form

Thank you for choosing our office.

In order to serve you properly, please provide the following information. Print clearly and leave no blanks.

Patient Name: _____ Today's Date: ____/____/____

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Address: _____ City _____ State _____ Zip _____

E-mail Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Marital Status: Single Married Divorced Widowed Separated

Gender: Male Female

Race: Caucasian African American Hispanic Asian Native American Other/Undetermined

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other or Undetermined

Employment: Employed Unemployed Disabled Retired

If Employed: Employer: _____ Phone: (____) _____

<input type="checkbox"/> Mother and/or <input type="checkbox"/> Guardian Name _____ Address _____ City _____ State _____ Zip _____ Date of Birth ____/____/____ SSN ____-____-____ Home Phone (____) _____ Cell (____) _____ Employer _____ Phone (____) _____	<input type="checkbox"/> Father and/or <input type="checkbox"/> Guardian Name _____ Address _____ City _____ State _____ Zip _____ Date of Birth ____/____/____ SSN ____-____-____ Home Phone (____) _____ Cell (____) _____ Employer _____ Phone (____) _____
Primary Insurance	Secondary Insurance
Employee _____ Employer _____ Name of Insurance _____ DOB ____/____/____ SSN ____-____-____ Policy # _____ Group # _____ Relationship to Patient _____	Employee _____ Employer _____ Name of Insurance _____ DOB ____/____/____ SSN ____-____-____ Policy # _____ Group # _____ Relationship to Patient _____

Patient's Primary Care Physician: _____ Phone: (____) _____

Referring Physician: _____ Phone: (____) _____

I hereby authorize any payment to Magnolia Regional Health Center's Owned Clinics for medical services under the terms of my insurance benefits. I authorize release of any medical information about me pertaining to claims. I consent to examination and treatment by Magnolia Regional Health Center's Owned Clinics. This consent will remain in effect from this date forward unless written revocation of such is duly presented to an office of Magnolia Regional Health Center's Owned Clinics by me or a legally authorized representative. I understand that I have the right to question and/or refuse any proposed treatment. I acknowledge I have been offered a copy of the Notice of Privacy Practices and the Patient Bill of Rights.

By signing this form, I verify and agree that the above numbers are my home and/or cell phone number(s). I also agree and consent to receive phone calls or text messages to these numbers via automated technology regarding my care, upcoming appointments, annual visits, recall notices, preventative care or an attempt to collect a debt. Message and Data rates may apply. I can choose to opt-out at any time by contacting my provider.

Signature: _____ Date ____/____/____



Authorization to Treat a Minor in the Absence of Parent or Legal Guardian

I (we) the undersigned parent, parents, or legal guardian of: _____ a minor, do hereby authorize the following person(s) to accompany my child to Magnolia Regional Health Center's Owned Clinics for medical treatment ordered and provided by Magnolia Regional Health Center's Owned Clinics and I (we) also authorize the following person(s) access to any medical information, patient care instructions, etc. pertaining to the medical treatment provided during the office visit. I (we) understand that if any person(s) other than those listed below company my child to Magnolia Regional Health Center's Owned Clinics for medical treatment, treatment will be delayed until authorization is obtained from the parent(s) or legal guardian.

Name of Authorized Person	Date of Birth	Relationship to Patient

List any restrictions: _____

Contact numbers where parents may be reached in case of emergency:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Signature of Father, Mother, or Legal Guardian

Date

Signature of Father, Mother, or Legal Guardian

Date



Authorization to Disclose Protected Health Information (PHI)-Individuals Involved in Care/Payment

Patient Name: _____ DOB: _____

By signing this paper below, I authorize all practices associated with Magnolia Regional Health Center’s Owned Clinics to share protected health information about the patient identified above with the individuals named below. The Recipient(s) are involved in the Patient’s care and/or payment for care, I authorize Magnolia Regional Health Center’s Owned Clinics to share such protected health information as the Recipient(s) may request, except as expressly limited below. I understand this form is legally binding and that I may revoke my authorization at any time by submitting my request to change, add, or terminate such permission in writing.

Name of Individual	Relationship	Instructions/Limitations*			Telephone Number
		Appointments	Clinical	Financial	

Person we may contact in case of emergency (other than living with you):
 Name: _____ Phone: _____ Relationship: _____

*If you wish to include any limits on information that may be shared with the Recipient(s) identified, you must list those limitations in the column above. Otherwise, by signing this form, you are authorizing all practices associated with Magnolia Regional Health Center’s Owned Clinics to share all information that the Recipient(s) may request.

In order to obtain information by telephone, Magnolia Regional Health Center’s Owned Clinics may require that the party calling be able to share the patient identifiers with the staff.

I agree that unless I have listed a specific expiration date or event above, all practices associated with Magnolia Regional Health Center’s Owned Clinics may rely upon this form and may disclose information based on this form until such practice receives written notice that I am revoking permission. I acknowledge that I have received a copy of this form. I understand that I have a right to revoke this authorization by written notice and I understand that no treatment, payment, enrollment or eligibility for benefits will be conditioned upon whether I sign this form. I understand the potential for information shared with the Recipient(s) to be further disclosed and no longer protected by applicable privacy laws.

Pharmacy Medication History

By signing below, I hereby authorized Magnolia Regional Health Center’s Owned Clinics to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of continued treatment. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Magnolia Regional Health Center’s Owned Clinics may not condition the provision of treatment, payment, enrollment in the health plan or eligibility for benefits on the provision of this authorization.

Signature: _____ Date: _____



MAGNOLIA REGIONAL HEALTH CENTER'S OWNED CLINICS
SIGNATURE PAGE

PRINT PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

Please initial verifying that you have read and agree to the following (if you disagree, write "Decline" in the blank):

_____ The Financial Policy.

_____ The Photo Consent.

_____ The HIPAA Rights.

_____ The Prescription Policy.

In efforts to reduce paperwork for patients and to improve patient care, the Magnolia Regional Health Center's owned Clinics seek to (i) have patients complete a single copy of each relevant form, rather than copies for each practice, (ii) have these forms accessible for all of the Magnolia Regional Health Center's owned Clinics, and (iii) maintain a unified medical record that is accessible to all of the Magnolia Practices. By signing below, you are acknowledging and agreeing that each of the Magnolia Regional Health Center's owned Clinics may rely upon forms you complete and information you provide, and may use and disclose the forms and information including for treatment, payment and health care operations for the Magnolia Regional Health Center's owned Clinics. You understand and agree that each of the Magnolia Regional Health Center's owned Clinics may be a separate legal entity, and none of the Magnolia Regional Health Center's owned Clinics will be responsible for acts or omissions of the other associated Magnolia Regional Health Center's owned Clinics.

Patient/Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____
(must be signed by a Magnolia owned Clinic Staff)