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: (_____) _____

□ **Mother and/or □Guardian**	□ **Father and/or □Guardian**
Name _____	Name _____
Address _____	Address _____
City _____State _____Zip _____	City _____State _____Zip _____
Date of Birth___/____/_____ SSN ____-____-_____	Date of Birth___/____/_____ SSN ____-____-_____
Home Phone (____)_____ Cell (____)_____	Home Phone (____)_____ Cell (____)_____
Employer _____Phone (___)_____	Employer _____Phone (___)_____
Primary Insurance	**Secondary Insurance**
Employee _____	Employee _____
Employer_____	Employer_____
Name of Insurance_____	Name of Insurance_____
DOB ____/_____/_____SSN____-_____-_____	DOB ____/_____/_____SSN____-_____-_____
Policy # _____Group # _____	Policy # _____Group # _____
Relationship to Patient _____	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 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
One Patient at a Time.

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)