



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