Premise Health™
Keep your edge

PATIENT DEMOGRAPHIC SHEET

Review and update annually to ensure up to date information. Complete new form if necessary.

PLEASE PRINT

NAME _____
(Last Name) **(First Name)** **(Middle Initial)**

Title (circle): **Dr.** **Mr.** **Mrs.** **Miss** **Ms.**

Date of Birth:	
Home Address: (street) (city) (state) (zip code)	
Home Telephone Number: (include area code)	**Employer:**
Work Telephone Number: (include area code)	**Location:**
Cell Telephone Number: (include area code)	**Employment Status:**
Pager:	**Department:**
E-Mail address:	**Job Title:**

EMERGENCY CONTACT		
Name of Person to contact. What is his/her date of birth? (Last Name)	(First Name)	(Middle Initial)
How is this person related to you?		
Telephone number of person to be contacted:		

INSURANCE/PROVIDER INFORMATION	
Do you have (Co Name) insurance?	**YES** **NO**
Primary Care Physician: YES NO	**If Yes: Name:** **Telephone Number:**
Health Insurance: YES NO	**If Yes: Carrier:**
Prescription Coverage: YES NO	**Preferred Drug Store:**
	Location:
	Phone Number:

Signature of Person Completing Information _____

Date completed_____Date(s) reviewed_____

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Treatment and Medication History Consent and Patient Acknowledgment of the Notice of Privacy practices and Consent to Use and Disclose Health Information

I consent to all necessary steps taken for examination, diagnosis and treatment. If at any time I have questions about my examination, diagnosis, or treatment, I will not proceed until my questions have been answered so that I am fully informed. I understand that giving the providers and nurses all relevant information is important to my proper diagnosis and treatment. I understand active participation in discussions about my treatment and adherence to the agreed upon treatment plan are critical to the success of my treatment.

If required by law, I acknowledge that I was provided with an opportunity of a copy of the Premise Health Notice of Privacy Practices regarding uses and disclosures of information regarding me and my health ("Health Information"). I hereby consent to the use and disclosure of my health information, for the purposes and activities permitted under the federal privacy and state privacy laws, which are described in the Premise Health Notice of Privacy Practices.

I specifically authorize the release, to the fullest extent permitted by law, for treatment, payment or operations purposes as described in the Notice of Privacy Practices, of information regarding the results of any HIV/AIDS testing or treatment, mental health treatment and substance abuse treatment.

I authorize Premise Health to release my health information to my health plan or to a health and wellness provider approved by my health plan for purposes of advising me concerning appropriate measures to maintain or improve my health or any condition reflected in my records.

I authorize Premise Health to release information to my designated insurance plan for the purpose of health plan administration, including receiving or making payment for services rendered on my behalf. I understand a patient is responsible for all charges incurred, subject to contract and program rules, regardless of my insurance status. If it becomes necessary to send this account to collections, the patient will be responsible for all additional charges.

I have read and do understand the above information.

_____ _____
Patient/Personal Representative Signature Date

_____ _____
Patient/Participant Name (please print) Date of Birth

Relationship of Personal Representative (parent/legal guardian): _____

FOR SITE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
_____ Patient did not sign or refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please describe: _____)

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DISCLOSURES TO FAMILY, FRIENDS AND OTHERS INVOLVED IN HEALTH CARE OR PAYMENT

Except under emergency circumstances or if I am incapacitated, I agree that the Site **may share** my medical information with the individuals listed below who are involved in my care or payment for my care. If no names are provided by me or my personal representative, then I agree that my medical information could be shared with individuals who may be involved in my care or payment.

If you wish that no one receive my health information, mark "None" at the bottom of the form.

1. Spouse (name): _____
2. Children/Family Members (names): _____

   _____
3. Family or Others (names): _____

   _____

☐ None

Patient/Legal Representative Signature: _____

Print Name: _____

If not patient, Relationship of Legal Representative (parent, legal guardian):

_____

Date: _____

Date of Birth: _____