Oakstone Health Center

Patient Information: This information refers to the patient only.

Social Security Number:_____ **Employed** ____ **Retired** ____

Last Name:_____ **Jr., II,** _____ **Employer:**_____

First Name:_____ **Middle Name**_____ **Address:**_____

Maiden Name:_____ **Spouse Name:**_____ _____

Address:_____ **Zip Code:**_____

Zip Code:_____ **City:**_____**State:** _____ **City/State:**_____

E-mail Address: _____@_____. _____ **Cell Phone: (**____**)**_____

Home Phone: (_____**)**_____ **Primary Care Physician:**_____

Work Phone: (_____**)**_____ ext: _____ **Referring Physician:**_____

Birth Date (mm/dd/yy): _____**Age** _____ **If Student Full-Time Part-Time**

Race: Caucasian Hispanic African-American Other:_____ **Sex: Male Female**

Marital Status: Married Single Divorced Widowed

Responsible Party: This section refers to the PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: Self(skip to next section) Parent Spouse Other:_____

Social Security Number:_____ **If Employed, Employer:**_____

Last Name:_____ **Jr., II,** _____ _____

First Name:_____ **MI**_____ **Address:**_____

Address:_____ _____

Zip Code:_____ **City:**_____**State:** _____ **Zip Code:**_____

Home Phone: (_____**)**_____ **City/State:**_____

Work Phone: (_____**)**_____**Ext**_____ **If Student Full-Time Part-Time**

Birth Date (mm/dd/yy):_____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Subscriber Information: This section refers to the PERSON IN WHOSE NAME THE INSURANCE IS LISTED

Relationship to Patient: Self(skip to page 2) Parent Spouse Other:_____

Social Security Number:_____ **If Employed, Employer:**_____

Last Name:_____ **Jr., II,** _____ _____

First Name:_____ **MI**_____ **Address:**_____

Address:_____ _____

Zip Code:_____ **City:**_____**State:** _____ **Zip Code:**_____

Home Phone: (_____**)**_____ **City/State:**_____

Work Phone: (_____**)**_____**Ext**_____ **If Student Full-Time Part-Time**

Birth Date (mm/dd/yy):_____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Please ensure the office has a copy of your most recent insurance card(s)

INSURANCE COVERAGE INFORMATION: Please show all numbers on your card(s).

PRIMARY INSURANCE COVERAGE:

Insured (Name on card):_____ **Insured ID Number:**_____

Insurance Co. Name:_____ **Group/Member/Policy Number:**_____

Oakstone Health Center

Address:_____ **Effective Date:**_____

SECONDARY INSURANCE COVERAGE:

Insured (Name on card):_____ **Insured ID Number:**_____

Insurance Co. Name:_____ **Group/Member/Policy Number:**_____

Address:_____ **Effective Date:**_____

ACCIDENT INFORMATION….

Is your injury a result of a work related accident? Y / N **Date of Accident:**_____

Is your injury a result of an automobile accident? Y / N **Date of Accident:**_____

IN CASE OF EMERGENCY . . . .

Name and Phone number of nearest relative NOT living with you (include relationship):

_____ _____

AUTHORIZATION FOR TREATMENT AND TO PAY BENEFITS TO THE PHYSICIAN . . . .

I attest that this information is true and correct to the best of my knowledge. I confirm that I have received a copy of the Oakstone Health Center *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I authorize the office of Oakstone Health Center. to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept financial responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

_____ _____

Date **Signature of Patient and / or Guardian, if patient is Minor**

Consent and Authorization for Alternative Means of Communication

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means; such as sending correspondence to the individual's office.

I wish to be contacted in the following manner:

Home Phone:
OK to leave message with info? Yes No

Cell Phone:
OK to leave message with info? Yes No

Work Phone:
OK to leave message with info? Yes No

_____

Signature of Patient and / or Guardian, if patient is Minor