ROPER ST. FRANCIS
PHYSICIAN PARTNERS

PATIENT INFORMATION FORM

Referred by: _____ **Primary Care Physician**: _____

Last Name: _____ **First Name:** _____ **Prefix** ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Middle Name: _____ **Preferred Name:** _____

Date of Birth: _____ /_____ /_____ **Age:** _____ **SSN:** _____ - _____ - _____

Address: _____ **City:** _____**County:** _____ **State:** _____ **Zip:** _____

Email: _____ **Home:** ( )_____-_____ **Cell:** ( )_____-_____**Work:** ( )_____-_____

May we leave a message about appointments or normal test results on the phone numbers you provided? ☐ Yes ☐ No

Would you like to receive appointment reminders via text message on your cell phone? ☐ Yes ☐ No

You consent to receive text messages from us that may contain health information or advice. You are not required to provide consent in order to receive such information or advice from your provider. Standard text messaging rates may apply.

Alternate Contact: **If you want us to contact you at an alternate address or telephone number, please provide below:**

Alt. Address: _____ **City:** _____ **State**: ____ **Zip**: _____ **Phone**: ( )_____-_____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐ Unknown

Ethnicity: ☐ Not Hispanic / Latino ☐ Hispanic / Latino ☐ Declined to Specify

Race: ☐ White ☐ Black / African American ☐ Asian ☐ American Indian / Alaska Native ☐ Native Hawaiian / Other Pacific Islander ☐ Declined to Specify ☐ Other Race

Birth Sex: ☐ Male ☐ Female **Gender Identity (optional):** _____

Sexual Orientation (optional): ☐ Straight/heterosexual ☐ Lesbian ☐ Gay/homosexual ☐ Bi-sexual ☐ Choose not to disclose ☐ Other

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Other: _____

Student Status: ☐ N/A ☐ Full-time ☐ Part-time **Employment Status**: ☐ N/A ☐ Full-time ☐ Part-time **Employer:** _____

Name of Pharmacy: _____ **Address**: _____ Phone: ( ) _____-_____

Emergency Contact Name: _____ **Relationship**: _____ Phone: ( ) _____-_____

Guarantor/ Person Financially Responsible For the Payment If Other Than The Patient

Last Name: _____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Other: _____ Sex: ☐ Male ☐ Female

First Name: _____ Date of Birth: ____/____/____ Age: _____ SSN: ____ – ____ -_____

Middle: _____ Relationship to Patient: _____+_____

Address: _____ City: _____ State: _____ Zip: _____

Home: ( ) _____-_____ Cell: ( ) _____-_____ Work: ( ) _____-_____

Email Address of Guarantor/ Person Financially Responsible: _____

Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID #: _____

Policyholder Date of Birth: _____

Insurance Co. Phone #: _____

Group #: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID #: _____

Policyholder Date of Birth: _____

Insurance Co. Phone #: _____

Group #: _____

Relationship to Patient: _____

ROPER ST. FRANCIS HEALTHCARE

Completed form to be scanned into **Patient Communication Release of Information** in the medical record

Patient Communication Release of Information

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I consent and authorize Roper St. Francis Healthcare to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the RSFH Notice of Privacy Practices, a copy of which has been made available to me. I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes. A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep RSFH informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

ONGOING COMMUNICATION: DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL(S) WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITIONS? IF YES, TO WHOM?

Unless otherwise specified, by listing an individual and/or entity below, you authorize ALL RSFH locations to release and/or discuss your health information with the individual and/or entity you have listed.

Specific information to be disclosed: (Check all that apply)

- ☐ Appointment details/reminders
- ☐ Test results (Lab, Pathology, Cardiac, Radiology)
- ☐ Immunization record
- ☐ Medications
- ☐ Physician progress notes/office visit notes
- ☐ Discharge summary
- ☐ Emergency Department record
- ☐ Billing information
- ☐ Other: _____

Name of hospital or physician practice to disclose information:

- ☐ Hospital: _____
- ☐ Physician/Practice name: _____
- ☐ Other healthcare provider: _____

Date range or event of information to be released, select one:

Beginning Date / Event to be Released: _____ End Date / Event to be Released: _____ Or ☐ All Treatment Dates

*Any revocation or modification to your authorization regarding an individual or organization must be submitted in writing.

** A separate **Authorization to Release Information Form** must be completed to release and/or discuss your health information with any individual(s) and/or entity(s) not listed here. ***Authorization is not required for treatment purposes.***

Authorized Individual or Entity	Phone Number	Relationship	Address
_____	(_____)_____	_____	_____
_____	(_____)_____	_____	_____

For your convenience, please specify any individuals you authorize to pick up your item(s) from RSFH provider(s)

Name of Individual	Phone Number	Relationship	Authorized to pick up: (prescriptions, paperwork, etc.)
_____	(_____)_____	_____	
_____	(_____)_____	_____	_____

Print Patient's Name: _____

Patient's Signature: _____ Date: _____ /_____ /_____

Print Legal Guardian's Name: _____

Legal Guardian's Signature: _____ Date: _____ /_____ /_____

This authorization is valid for one year from date signed.