PATIENT AUTHORIZATION & DEMOGRAPHICS

Patient Information:

Social Security #: _____ **Home Phone #:**_____

First Name: _____ **Cell Phone #:** _____

Last Name: _____ **Email:** _____

Middle Name: _____ **Information / Marketing Communication:** ☐ Y ☐ N

Preferred Name: _____ **Patient Reminders Communication:** ☐ Y ☐ N

Birthday: _____ **Preferred Method of Communication:** ☐ No Preference ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Mail

Gender: ☐ Female ☐ Male **Marital Status:** ☐ Child ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

Address:_____ **Employer Name:** _____

Zip:_____ **Employer Phone:**_____

City & State: _____

Employment Status: ☐ Disabled ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Student ☐ Not Employed

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Additional Information:

Primary Care Physician: _____ **Office Phone #:** _____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

Pharmacy Address: _____

Parent or Legal Guardian:

First Name: _____

Last Name: _____

Middle Name: _____

Relationship: _____

Address: _____

City: _____

State: _____

Zip: _____

Primary Phone #: _____

Email: _____

Demographics:

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Patient Declines

Ethnicity: ☐ Hispanic or Latino ☐ Patient Declines ☐ Not Hispanic or Latino

Preferred Language: _____

Insurance Info: (Guarantor)

Name Last: _____ First: _____

Address: _____

City: _____State: _____

Zip: _____Phone: _____

Social Security #: _____Birthday: _____

Gender: ☐ Female ☐ Male **Relationship: _____**

Employer Name: _____

Do you have insurance with more than one health plan?:

☐ Y ☐ N

Secondary Insurance: _____

Subscriber Name: _____

SSN: _____ DOB: _____

Address: _____

_____

Employer Name: _____

On-The-Job Injury \ Occupational Testing Employer Info:

Name _____

Address: _____

_____

City: _____

State: _____ Zip:_____

Phone: _____

Phone: _____

Additional On-The-Job Injury Information:

If Injury, Exact Date of Injury: _____

Is your employment through a temporary service?

Name of Temp Service: _____

Is your employment through an independent contractor?

Name of Contractor: _____

Status: ☐ Disabled ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Student ☐ Not Employed

Authorization for treatment, Assignment of insurance benefits, Guarantee of payment, Release of records:

EMERGENCY CONTACT:

By listing an emergency contact below, I am authorizing CareNow to disclose information to the named individual concerning my medical condition(s), billing account details and be contacted in the event of an emergency situation. I am aware that any disclosure of my protected health information outside of verbal communication will require a HIPAA compliant authorization be completed, in accordance with the Notice of Privacy Practices.

Contact Name: _____ Relation to Patient: _____ Phone: ( )_____

Address:_____ Apt#:_____ City:_____ State:_____ Zip:_____

Patient \ Legal Guardian Signature:_____ **Date: _____**

Printed Patient \ Legal Guardian:_____

Revised: 07/11/2016cg