DEMOGRAPHIC FORM

Last Name____________________________________ First Name________________________________ MI__________

DOB ____________ SSN# _______________Previous Name(s) ________________________ Gender (circle) M / F / T

Mailing Address____________________________________ City ______________ State _______ Zip ___________

Physical Address __________________________________ City ______________ State ________ Zip __________

Home Phone ______________Cell Phone _______________ Employer ________________ Work Phone ___________

Race _____________________ Ethnicity ________________ Language ______________________

Marital Status (circle) Single / Married / Divorced / Separated / Widowed

E-mail ____

RESPONSIBLE PARTY (MINORS ONLY)

Last Name _______________________ First Name ________________________ MI ______ Gender (circle) M / F / T

Mailing Address ________________________________ City _____________ State _______ Zip ___________

Home Phone ____________DOB__________ SSN# ________________Relationship to Patient ____________

INSURANCE INFORMATION

Primary Insurance ________________________ Policy # ___________________ Group #_________________

Policy Holder Name __________________________________ DOB ____________ SSN# ________________

Secondary Insurance ______________________ Policy # ___________________ Group # ________________

Policy Holder Name __________________________________ DOB ____________ SSN# ________________

GENERAL INFORMATION

Emergency Contact Name _____________________________ Phone _____________ Relationship _________

Preferred Pharmacy _____________________________ Primary Care Provider ______________________________

Who in your family may we discuss your health with? Name(s) ___________________ Relation(s) ______________

Who do you authorize to pick up your prescriptions? Name(s) ____________________ Relation(s) ______________

CONSENT TO TREATMENT: I hereby consent to all medical and surgical treatment, X-ray, laboratory, anesthesia and other medical procedures as may be performed or prescribed by the physician or any persons whom he may designate. I also consent to Northwoods Family Medicine obtaining my prescription history from external sources including pharmacies and The Alaska Prescription Drug Monitoring Program.

RELEASE OF BENEFITS AND INFORMATION: I authorize my insurance benefits to be paid directly to the doctor. **I am financially responsible for any balance due**. I authorize the doctor to release any information required for this claim to my employer and/or insurance company.

NOTICES OF PRIVACY PRACTICES/PATIENT RIGHTS/HIPPA: I was offered information about privacy practices, patient rights, and HIPPA Laws. All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used as follows only with patient consent. I hereby authorize Northwoods Family Medicine to furnish information to other providers, healthcare or treatment facilities, and my insurance companies for purposes of treatment, payment, and healthcare operations.

I attest the above information is true and accurate to the best of my knowledge.

Signature ____ Date _________________