



PRACTICE: Long Point Urgent and Family Care PT #: _____

Patient Identification

Last Name: _____ Mr. Mrs. Miss SSN: _____ - _____ - _____
First Name: _____ Other title _____ Date of Birth: ____/____/____
Middle: _____ Race: _____ Sex: Male ____ Female ____
Marital Status: Married Single Separated Divorced Widowed Relationship to Guarantor: _____
Student Status: Full Part N/A School: _____ Phone: () _____
Employment: Full Part None Employer: _____ Phone: () _____
Address: (This practice will send all correspondence to this address unless you provide us an alternate address below)
Street: _____ City: _____ State: _____ Zip: _____
Phone: () _____ (RSFH will contact you at this number unless you provide us an alternate number below)
E-mail _____
May we leave a general voice message for appointment reminders at this contact phone number? Yes _____ No _____
May we leave a general voice message for normal test results at this contact phone number? Yes _____ No _____
Preferred Pharmacy : _____
In Case of Emergency Contact Name _____
Relationship _____ Home Phone () _____ Work Phone () _____

Guarantor/Responsible Party (if different from patient)

Last Name: _____ Mr. Mrs. Miss SSN: _____ - _____ - _____
First Name: _____ Other title _____ Date of Birth: ____/____/____
Middle: _____ (Doctor, General, the III, etc...) Sex: Male ____ Female ____
Address: _____ Phone: Home () _____
City: _____ State: _____ Zip: _____ Phone: Work () _____
(Complete only if you want the Practice to communicate with you at an address/phone different than you provided above)
Alternate Address: _____ Alternate Phone: () _____
City: _____ State: _____ Zip: _____

Primary Insurance

Secondary Insurance

Member/Policyholder (if different from patient)		Member/Policyholder (if different from patient)			
_____	_____	_____	_____		
Member/Policyholder ID#	Date of Birth	Member/Policyholder ID#	Date of Birth		
_____	_____	_____	_____		
Insurance Co. Phone Number	Group #	Insurance Co. Phone Number	Group #		
(____) _____	_____	(____) _____	_____		
Insurance Co. Address (Street Address/ P.O. Box)		Insurance Co. Address (Street Address/ P.O. Box)			
_____		_____			
City	State	Zip	City	State	Zip
_____	_____	_____	_____	_____	_____

Ongoing Communication Regarding Your Healthcare

We may release/discuss your health information with following individuals/organizations for the following dates of service, range of time, or event(s): From (MM/DD/YY) _____ To (MM/DD/YY) _____

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate authorization must be completed if the information being release differs between the individuals/organizations listed above.

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Roper Saint Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

I have been provided a copy of the Roper Saint Francis Healthcare Notice of Information Practices.

Signed: _____ Date ____/____/____

Office Use Only:
