**Cross Road Medical Center**

# CONFIDENTIAL PATIENT INFORMATION

**Thank you for choosing us! As a Federally Qualified Health Center and in order to serve you properly, we request you provide the following information. Required information is marked with ***

Patient Name: *_____ SSN: *_____ Date of Birth:*_____

Mailing Address: *_____ City: *_____ State: *_____ Zip:*_____

Home Phone:*_____Cell :_____ Email:_____

Physical Address:_____ Veteran*: *Yes / No* Primary Language: _____

Is Cross Road your primary care provider? *Yes/No* If *No*, who is your primary care provider?_____

**Ethnicity/Race:** (Circle One) *Hispanic/Latino Asian White Black/African American Native Hawaiian Other Pacific Islander Alaska Native/American Indian More than 1 Race*

**Sexual Orientation:** (Circle One) *Lesbian, gay or homosexual Straight or heterosexual Bisexual Something else Don't know Choose not to disclose*

**Gender Identity:** (Circle One) *Male Female Transgender Male/Female-to-male Transgender Female/Male-to-Female Other Choose not to disclose*

## *EMERGENCY CONTACT/RELEASE OF INFORMATION

You may discuss my medical needs or exchange information with the following:*

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

□ **I do not want information released to anyone, including my spouse and/or other household members.**

## *COMPLETE IF PATIENT IS 0 -17 YEARS OF AGE:*

Parent/Legal Guardian:_____
Birthdate: _____ Address:_____
_____
Home Phone: (_____)_____Cell Phone: (___)_____
Work Phone:(____)_____

Parent/Legal Guardian: _____
Birthdate:_____ Address: _____
_____
Home Phone: (___)_____ Cell Phone: (___)_____
Work Phone: (_____)_____

## *INSURANCE INFORMATION-Indicate which is primary/secondary as well as cardholder's DOB*

**PRIMARY INSURANCE:**

Name of Primary Insured/Cardholder:*_____ Relationship to Patient:*_____

Patient ID #:*_____ Birth Date of Primary Insured:*_____

Insurance Company:*_____ Group #:*_____SSN of Primary Insured:*_____

Insurance Address and Phone: *_____

**SECONDARY INSURANCE:**

Name of Primary Insured/Cardholder:_____Relationship to Patient:_____

Patient ID #:_____Birth Date of Primary Insured: _____

Insurance Company:_____ Group #:_____ SSN of Primary Insured: _____

Insurance Address and Phone: _____

**PLEASE FILL OUT OTHER (REVERSE) SIDE**

**Cross Road Medical Center**

# CONFIDENTIAL PATIENT INFORMATION

## EMPLOYMENT/STUDENT INFO (optional)

Occupation: (*Indicate if Student*)_____ Seasonal Worker*: Yes/No*

Employer/School Name:_____ Work/School Phone:_____

Business/School Address:_____ City:_____State:_____ Zip:_____

## RESPONSIBLE PARTY ( if different from Patient)

Name of person responsible for this account:*_____ Relationship to Patient:*_____

Address:*_____ Phone:*_____SSN:*_____ Date of Birth:*_____

## ACCIDENT/INJURY INFORMATION ( if applicable)

Insurance Company:_____ Claim #:_____

Contact Name:_____ Phone No.:_____

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

Date of Injury:_____ Date Returned to work:_____

## *CONSENT AND ACKNOWLEDGMENT*

**CONSENT:** The information on this form is true to the best of my knowledge. I consent to be examined and receive treatment at Cross Road Medical Center.

**PATIENT'S RIGHTS / PRIVACY NOTICE:** If I want one, I have been given a copy of Cross Road Medical Center's Patient's Rights and Privacy Notice.

**RELEASE OF INFORMATION:** I authorize Cross Road Medical Center to release any information required to process my claims. This authorization and assignment is a permanent, one-time signature that will remain on file and be used for future visits and claims. This release may be revoked by me at any time by written notice.

**TRAINING FACILITY:** I understand that occasionally, health care students will be working with my provider. I give consent to have a health care student observe or participate in my (or my child's) care while under the supervision of my provider. I understand that these health care students are under the same confidentiality policies as my provider. I acknowledge that I have the option of declining this consent.

**ASSIGNMENT:** I acknowledge my responsibility to pay for the care I receive according to the fees established. I authorize my insurance / Medicare / Medicaid benefits to be paid directly to Cross Road Medical Center. I understand that I may be responsible for any deductibles, co-insurance, and non-covered charges. I understand that I may be responsible for charges that have not yet been calculated. I understand that I am responsible for any charges not paid by my insurance company and any unpaid charges (including those that should be covered by insurance) may be sent to a collection agency and my credit report may be adversely affected.

**To the best of my knowledge, the above information is correct, and I acknowledge will be put into my record:**

*_____ *_____

**Signature of Patient (or Parent / Legal Guardian)** **Date**