Cross Road Health Ministries

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 CRMC/IAMC your primary care provider? *Yes/No* If *No*, who is? _____

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*

Marital Status: (Circle One) *Single Married Divorced Widowed*

*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.**

INCOME Optional – Sliding Fee Scale Applicants

Household/Family Size: (Circle One) 1 2 3 4 5 6 7 8 _____

Household Yearly Income: $_____ OR Household Weekly Income: $_____

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 Health Ministries

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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 Health Ministries.

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

RELEASE OF INFORMATION: I authorize Cross Road Health Ministries 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 Health Ministries. 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**