**HEALTH MINISTRIES CLINIC, INC. – FORMULARIO DEMOGRAFICO DEL PACIENTE**

**Informacion del Paciente: Por favor escriba claramente. Este document es parte de el archive permanente del paciente.**

**Nombre completo:** Fecha de nacimiento**:**

**Domicilio, Ciudad, Estado, Codigo postal:**

**SS #:**  **Estado Civil:**  S  C  D  V **SEXO:** Masculino Femenino

Transgenero

**Idioma preferido:** **Etnicidad:**  Hispano  No-Hispano

**Raza:**  Caucasico  Negro/Afro Americano  Asiatico  Indio Americano/Nativo de Alaska  Hawaiano

**Veteran Status:**  Yes  No **Email Address:**

**Home Phone #:** **Cell Phone #:** **Work Phone #:**

**Pharmacy Preference:**

**Medical Insurance Name:**

(Please provide Insurance card)

**Medical Insurance Policy #:** **Group #**

**Policy Holder’s Name:** **DOB:** (must be provided)

**Guarantor Information:** Same as patient

Name: Phone #:

Address, City, State Zip:

**Emergency Contact Information:**  (if same as Guarantor, please check box)

Name: Relationship:

Phone #:

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| **PATIENT’S SIGNATURE REQUESTED IN 3 PLACES** |
| **ASSIGNMENT OF BENEFITS**  Please remember the insurance contracts are made between the patient and the insurance company. Often the insurance does not provide full payment of medical costs. Payment of the bill is, therefore, your responsibility. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize payment of medical benefits to Health Ministries Clinic for services rendered to myself.  Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Signed: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE ON FILE will automatically print on your claim form, allowing your insurance to pay us directly. |
| **MEDICARE AUTHORIZATION**  I request that payment of authorized Medicare benefits be made to me or on my behalf to Health Ministries Clinic for any services furnished me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.  Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Signed: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **RECORDS RELEASE**  I hereby authorize the release of any information, including medical and billing information, by Health Ministries Clinic to my referring doctor and/or insurance company.  Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Signed: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |