BONNER GENERAL HEALTH
QUALITY COMPASSIONATE CARE

Outpatient Clinics
Demographic Form

Reason for visit: _____ Date of Injury: _____
❑ Work Related ❑ Other

PATIENT INFORMATION:

Patient Name (Last, First, MI)		Maiden/Former Last Name	Sex: ☐ F ☐ M
Preferred Name	Date of Birth	Social Security Number	Marital Status
Mailing Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
E-mail Address	Primary Care Doctor		
What is your preferred Pharmacy?		May we access your prescription history? ☐ Yes ☐ No	
What is your race?	Hispanic ☐ Non-Hispanic ☐		
What is the best way to contact you? ☐ Home ☐ Cell ☐ Work	Does your phone have secured voicemail that we may use for leaving messages? ☐ Yes ☐ No		
Patient's Employer	Occupation	Employer Phone	
How did you hear about us? ☐ Internet ☐ Phone Book ☐ Printed Ad ☐ Family/Friend ☐ Doctor _____ ☐ Other _____			
Emergency Contact/Other Guardian: (Name – Last, First)		DOB:	
Home Phone	Cell Phone	Relationship to Patient:	

COMPLETE ONLY IF GUARDIAN IS DIFFERENT FROM PATIENT:

Guarantor/Guardian: (Name – Last, First)		Relationship to Patient:	Sex: ☐ F ☐ M
DOB	SSN	Home Phone	Cell Phone

PRIMARY INSURANCE COVERAGE		SECONDARY INSURANCE COVERAGE	
COMPANY/PROGRAM NAME		COMPANY/PROGRAM NAME	
Policy Holder Name		Policy Holder Name	
Insured DOB	SSN:	Insured DOB	SSN:
Group #	Policy #	Group #	Policy #
Relationship to Patient:		Relationship to Patient:	

To the best of my knowledge, all of this information is true and complete. I understand that I am responsible to pay for all services rendered to me. I am willing to make specific arrangements to pay any part not covered by insurance on a timely basis. A photocopy of this assignment is to be considered as valid as the original. If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made directly to the practice, for any service provided me by the practice's providers.

MEDICAL AND SURGICAL CONSENT: The undersigned hereby consent to any Medical, Surgical, Anesthetic, Laboratory, Medication, and/or X-Ray procedures which the physician/allied health professional may order. It is understood that the patient is under the direction of the attending physician/allied health professional and the clinic is not liable for any act or omission on the part of the physician/allied health professional.

NOTICE OF PRIVACY PRACTICES: Bonner General Health's notice of privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting it. A copy will be supplied upon request. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, health care operations and acknowledge receipt of the Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

PATIENT RIGHTS: Every patient has rights and responsibilities. By signing this form you agree you have been advised of your rights as a patient. A copy can be provided to you on request.

RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS: Bonner General Health may disclose all or part of the patient's medical or Financial Records to any person or corporation which may be liable under a contract to the clinic, including, but not limited to the patient, Insurance Carriers, or Welfare Funds. In the event the patient is entitled to clinic benefits of any type arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to the clinic for application to the patient's bill. The undersigned also gives the clinic and/or their representative permission to initiate a claim, on behalf of the patient, to any entity, person, or business that may be responsible for payment of services rendered.

Patient Signature: _____ Date: _____

Signature of Parent/Guardian (if patient is a minor): _____ Date: _____