UI Student Health Patient Information Form

PATIENT CONTACT INFORMATION:

Patient Name:_Last_____First_____MI_____
Student ID #:_____Patient's Date of Birth:_____
Local Mailing Address:_____
City: _____State:_____ Zip Code:_____
Cell Phone: _____Alternate Phone:_____
Sex:_____ Marital Status: S M W D SSN:_____
Permanent (Parents) Address if different from above:
Street Address:_____
City: _____State:_____ Zip Code: _____

INSURANCE INFORMATION:

Patient's Primary Insurance Plan: ☐ SHIP ☐ Other (if other, please fill out info below)
Name of Insurance Company: _____
Insurance Address: _____City_____State_____Zip_____
Policy or ID #: _____Group #: _____Co-pay Amount:$____
Policy Holders Name:_____Relation:_____
Policyholders Date of Birth: _____SSN#:_____Sex:_____
Policyholder Address:_____
City_____State_____Zip_____
Policyholders Employer: _____

QUALITY REPORTING:

Language:_____e.g. English, Spanish, Mandarin
Race:_____e.g. Caucasian, African American, Asian
Hispanic or Latino:_____Yes/ No
Preferred Method of Communication:_____e.g. Email, Phone, Mail

RELEASE OF INFORMATION:

I authorize you to discuss my health status and care with the following parties. This authorization will continue in for until I revoke it in writing. I understand that information released in this manner may be subject to re-disclosure by the recipient.

Authorized Party	Relationship to Patient	Phone Number
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

PRIVACY POLICY & SIGNATURE:

I have completed this form accurately to the best of my knowledge and certify that I am the above-named patient or the duly authorized general agent of the above- named patient, authorized to furnish the information requested. I understand that, even though I may have insurance coverage, I am responsible for payment for all services rendered. I authorize the release of any medical information necessary to process my insurance claims. I also request payment of medical benefits to Moscow Family Medicine, PA for services provided to the above-named patient. Further, I have been offered a copy of Moscow Family Medicine's Notice of Health Information Practices, which describes how my health information is used and shared. I understand that Moscow Family Medicine has the right to change this notice at any time. I may obtain a current copy by asking a receptionist or by visiting Moscow Family Medicine's web site at www.MoscowFamilyMedicine.com.

Signature:_____Date:_____