FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM

Patient Information Sheet

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Patient Information

Name _____ Social Security # _____ Sex: M F Other
Last First Middle

Date of Birth _____ other known name(s) _____

Mailing Address _____ _____ _____ _____
City State Zip

Preferred contact number _____

Would you like to receive SMS text messages for appointment reminders? Yes/No

Email address _____ Language ☐ English ☐ Spanish ☐ Other _____

Marital Status: (circle one)
Married
Legally Separated
Widowed
Unknown
Divorced
Single
Significant Other
Other

Ethnicity: (circle one)
Hispanic or Latino
Not Hispanic or Latino
Unknown
No Answer

Race: (circle one)
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White or Caucasian

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Guarantor Information (If different from patient)

Name _____ Social Security # _____ Sex: M F Other
Last First Middle

Date of Birth _____ other known name(s) _____

Mailing Address _____ _____ _____ _____
City State Zip

Relationship to patient _____ Preferred contact number _____

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Employer if applicable (Responsible party if patient is a child) _____

Employment Status: (circle one) disabled full time part time not employed on active military duty retired
Self-employed student full-time student part-time unknown

Please indicate any special needs you may have. _____

Primary Care Provider _____

Do you have an Advanced Directive? Yes/No (circle one)

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Insurance Information (Please circle)

None| Self| Commercial| Medicare| Medicaid- if insured please present card to clinic representative

(Primary Coverage)

Insurance Company _____

Member ID # _____

Subscriber Name _____

Relationship to Patient _____

Effective Date _____ Group #_____

Group # _____

Covered Through: (circle one) Current employer Retirement
Cobra/continuation of benefits
Other _____

(Secondary/Supplemental Coverage)

Insurance Company _____

Member ID# _____

Subscriber Name _____

Relationship to Patient _____

Effective Date _____ Group # _____

Group # _____

Covered Through: (circle one) Current employer Retirement
Cobra/continuation of benefits
Other _____

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Emergency Contact Name _____ Emergency Contact Phone Number_____

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Personal Representation Designation

Per the Health Insurance Portability and Accountability Act of 1996 you have the right to have one or more-person(s) act as your representative to make decisions about the uses and sharing of health information. Should you need to change your Designee at any point, please notify a clinic representative.

Designee(s) Name _____ Relationship to patient_____
Mailing address _____ Phone Number _____

Information permissions (Please circle) Financial and Demographic information |Healthcare Information |All Information

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Acknowledgement of receipt: (Please initial each)

Privacy Practices ____ Patient Responsibilities ____ Wellness Visit Notification Form ____ Patient Consent to Treat Form ____

By Signing below, I certify that all information is true and correct to the best of my knowledge:

Print Name of Patient/Parent/Guardian: _____ Signature of Patient/Parent/Guardian: _____
(Circle One)

Date: _____ Time _____