# NEW PATIENT INFORMATION FORM

## PATIENT INFORMATION

| Last Name | First Name | MI | Social Security Number |
|---|---|---|---|
| Street Address | City | State | Zip |
| Home Phone | Work Phone | Cell Phone | |
| Primary / Family Physician Name | E-Mail Address | Date of Birth | |
| Emergency Contact/Relationship to Patient | Emergency Contact Phone | | |

Race: ☐Asian ☐ Black ☐ Declined ☐ Hispanic ☐ American Indian ☐ Alaskan ☐ Other ☐ White

## INSURANCE CARD HOLDER INFORMATION

| Last Name | First Name | MI | Social Security Number | Date of Birth | Sex: ☐ M ☐ F |
|---|---|---|---|---|---|
| Home address (if different from patient) | City | State | Zip | Relationship to Patient | |
| Home Phone | Work phone | Employer's name through which your coverage is provided (if applicable) | | | |

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) – only complete this section if the patient is over age 18

The purpose of the Notice of Privacy Practices is to describe to you how Bay Care Clinic may use and disclose your protected health information, certain restrictions on the use and disclosure of your healthcare information and your rights regarding protected health information. BayCare Clinic will not make any unapproved disclosure of your PHI without your written authorization*. I hereby agree to permit BayCare Clinic to disclose my medical and billing protected health information to the following: (Example: spouse, friend, relative, etc. This does not apply to other physicians, insurance carriers, or attorneys).

Name: _____ Relationship: _____
(first and last name)

Name: _____ Relationship: _____
(first and last name)

☐ I do not authorize the release of my medical or billing information. Password: _____
(optional)

*This consent is subject to the provisions outlined in our Notice of Privacy Practices and includes **any** BayCare Clinic provider(s). This consent is valid Indefinitely unless amended or revoked.

## ADVANCED CARE PLANNING/ADVANCED DIRECTIVE – only complete this section if the patient is over age 18

Advanced Care Planning: Preparing for how your health care treatment options will be addressed when you are unable to speak for yourself. Advanced Directives (documents that speak for you) communicate with family & friends your preference for care.

| | |
|---|---|
| Living Will: States what you want, but does not give anyone authority to make decisions on your behalf. | Do you have a living will? ☐ YES ☐ NO |
| Power of Attorney for Healthcare: A document in which you appoint an agent to make decisions regarding your care when you cannot make your own decisions | Do you have a Power of Attorney for Healthcare? ☐ YES ☐ NO |
| If you answered "YES" to either of the above questions, please indicate where the document is kept below: | |
| If you answered "NO" to one or both of the above questions, would you like an Advanced Care Planning Packet? | ☐YES ☐ NO |

I certify the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health care insurance carrier or payer of my health benefits may pay less than the actual bill for services, and I am ultimately responsible for any balances. I also understand I am responsible for all second opinion and pre-admission review requirements. I acknowledge that BayCare Clinic has provided me with a copy of their Privacy Practices.

Signature: _____ Date: _____