Sandhills Medical Foundation, Inc.

PATIENT INFORMATION

BASIC INFORMATION (Please provide an acceptable picture ID)

Patient Name: _____ Age: _____

Date of Birth:_____ (mm) / _____(dd) / _____ (yyyy) SSN: _____ / _____ / _____

If Patient is a minor:

Parent/Guardian Name: _____ Phone#: _____

Parent/Guardian Date of Birth:_____ / _____ / _____ SSN: _____ / _____ / _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ ☐ Home ☐ Cell Alternate#: _____

Email (**required for Online Services Access**): _____

Emergency Contact:

Name: _____ Relation to Patient: _____

Phone#: _____ Address: _____

INSURANCE/MEDICARE/MEDICAID (Please provide insurance card(s) if applicable)

Mark all that apply: ☐ Medicare ☐ Medicaid ☐ Insurance

Plan Name: _____ Group #: _____

Policy ID #: _____ Effective Date: _____ / _____ / _____

Policy Holder: SSN: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

Secondary Plan Name: _____ Group #: _____

Policy ID #: _____ Effective Date: _____ / _____ / _____

Policy Holder: SSN: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

Are you interested in applying for our Sliding Fee Discount Program? ☐ **Yes** ☐ **No**

PERSONAL INFORMATION: By participating in federal programs, we are required to request the following information

Gender at Birth: ☐ Male ☐ Female ☐ Unknown ☐ Decline to Specify

Gender Identity: ☐ Male ☐ Female to Male ☐ Male to Female ☐ Female ☐ Gender Neutral ☐ Other:_____ ☐ Decline to Specify

Sexual Orientation: ☐ Heterosexual ☐ Bisexual ☐ Don't know ☐ Homosexual ☐ Lesbian ☐ Other: _____ ☐ Decline to Specify

Race: ☐ Black/African American ☐ American Indian/Alaskan Native ☐ White ☐ Asian ☐ More than one race ☐ Other: _____ ☐ Decline to Specify

Ethnicity: Hispanic or Latino? ☐ Yes ☐ No Primary Language: _____ Translator: ☐ Yes ☐ No

Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow(er)

Income:

Total Number of People Living in Household: _____

Total Household Income: $_____ ☐ Weekly ☐ Monthly ☐ Yearly ☐ Decline to Report

NOTE: THE INFORMATION ABOVE IS CONFIDENTIAL AND PLACED IN YOUR MEDICAL RECORD

EMPLOYMENT

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Employer Name: _____ Phone: _____

Are you a Student (University, Technical College, etc.)? ☐ Full-time ☐ Part-Time ☐ No

Are you a Migrant or Seasonal Worker? ☐ Yes ☐ No

OTHER

Do you have a Primary Caregiver? ☐ No ☐ Yes: Name: _____ Relation to Patient: _____

Phone#: _____ Address: _____

Do you have an Advanced Directive? ☐ No ☐ Yes ☐ Do not resuscitate ☐ Medical Power of Attorney ☐ Living will

(If yes to either above, we will need a copy of documentation for your records.)

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About Our Notice of Privacy Practices

At Sandhills Medical Foundation, Inc., we are committed to protecting your personal health information in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). The attached Notice of Privacy Practices states:

- How we may use and/or disclose the health information that we keep about you.
- You rights relating to your personal health information.
- Our obligations under the law with respect to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in the Notice.
- The person to contact for further information about our privacy practices.

We are required by law to provide you with a copy of the Notice of Privacy Practices and to obtain your written acknowledgement that you have received a copy of this notice.

A copy of the Notice of Privacy Practices and Patient Rights and Responsibilities is located in your New Patient packet, available upon request at the front desk and posted in the lobby of this facility.

Patient Acknowledgement of Receipt

I, _____, hereby acknowledge that I have received a
Print Name

copy of the Notice of Privacy Practices and Patient Rights and Responsibilities.

_____ _____

Signature of Patient/Other Date

_____ _____

Signature of Parent or Patient's Representative Date

_____

Description of Legal Authority to Act on Behalf of Patient