Renaissance
HEALTH AND SURGICAL ASSOCIATES

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PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

PATIENT INFORMATION

Patient Name: _____ **Patient's Social Security Number**:_____-_____-_____ **Date of Birth**:_____/_____/_____
(First) (Middle) (Last)

Address: _____
(Street) (PO Box/Apt #) (City) (State) (Zip)

Marital Status: ___S ___M___D___W **Gender**: ___F ___M **Language Preference if not English**:_____ **Other communication Issues?** N___ Y____ **(What?)**_____

Race: White ____ Black or African American ____ Asian ____ Native Hawaiian or Other Pacific Islander ____ American Indian or Alaska Native ____ Other ____

Ethnicity: NOT Hispanic or Latino____ Hispanic or Latino___ **Home Phone**: (_____)_____ **Cell Phone**: (_____)_____

Email Address: _____ **Preferred Method of Contact**: ____ Phone (please circle preferred phone number above) _____ Mail

Employer's Name: _____ Work Phone: (_____)_____

SPOUSE/GUARANTOR/PARENT INFORMATION

Responsible Party Name: _____ **Relationship to Patient**: _____
(First) (Middle) (Last)

Responsible Party Date of Birth: _____ **Guarantor's Social Security Number**: _____-_____-_____

Guarantor's Address_____
(Street) (PO Box/Apt #) (City) (State) (ZIP)

Home Phone: (___)_____ **Cell Phone**: (__)_____

Employer's Name: _____ **Employer's Address**: _____ **Work Phone**: (_____)_____
(Street) (City) (State) (Zip)

PATIENT's INSURANCE INFORMATION * Please provide Insurance Card and Photo ID to Receptionist

Primary Insurance Company's Name: _____ **Insurance Address**: _____
(Street) (PO Box) (City) (State) (Zip)

Primary Insurance Company's Phone Number (_____)_____ **Name Of Policy Holder**: _____ **Policy Holder's Date of Birth**; _____/_____/_____
(First) (Middle) (Last)

Policy Holder's Social Security Number: ____-_____-_____ **Policy Holder's Gender**: __M ___F **Policy Holder's Relationship to Patient**: _____

Employer: _____ **Insurance ID Number**: _____ **Group Number**;_____

Secondary Insurance Company's Name: _____ **Insurance Address**: _____
(Street) (PO Box) (City) (State) (Zip)

Secondary Insurance Company's Phone Number (_____)_____ **Name Of Policy Holder**: _____ **Policy Holder's Date of Birth**; _____/_____/_____
(First) (Middle) (Last)

Policy Holder's Social Security Number: ____-_____-_____ **Policy Holder's Gender**: __M ___F **Policy Holder's Relationship to Patient**: _____

Employer: _____ **Insurance ID Number**: _____ **Group Number**;_____

PATIENT's REFERRAL INFORMATION

Primary Care Physician:_____ **Address:** _____ **Phone**: (____) _____
(Street) (PO Box) (City) (State) (Zip)

Referring Physician: _____ **Address:** _____ **Phone**: (____) _____
(Street) (PO Box) (City) (State) (Zip)

How did you hear about us? ____Family _____Friend _____Radio _____TV _____Newspaper _____Other

EMERGENCY CONTACT INFORMATION (Please include other parent when applicable)

Contact #1 _____
First Last

Home Phone_____ Cell Phone_____

Work Phone_____

Patient Relationship to Contact _____

Contact #2 _____
First Last

Home Phone_____ Cell Phone_____

Work Phone_____

Patient Relationship to Contact _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS, NOTICE OF PATIENT PRIVACY PRACTICES

I hereby authorize my commercial insurance and/or Medicare benefits to be paid directly to RHASA for services rendered. I also authorize RHASA to release any information requested by the insurance company with regards to payment of benefits. **I acknowledge financial responsibility for all charges relating to my care at RHASA that are not covered by insurance.** I understand that I may be billed directly from other labs and/or facilities for charges incurred by multiple providers for services. I consent to treatment of the patient above as deemed necessary and appropriate by the attending provider.

Financial Policy: All balances are due and payable within thirty (30) days of the initial statement date unless prior arrangements have been made. Patient balances which are not resolved in a timely manner will be sent to an outside collection agency and/or attorney, and additional fees will apply. The person requesting treatment is responsible for all services rendered. I understand if problems are found or discussed during my annual visit, my insurance plan may require me to pay a co pay or deductible for the problem evaluation and management visit. However, if the patient is a minor, the custodial parent or guardian is responsible for all services rendered. Patients who do not show up on time or cancel appointments with less than 24 hour notice may be subject to a fee. By my signature below, I acknowledge that I may receive a more comprehensive financial policy by visiting www.rhasa.com, requesting a copy at any of RHASA's locations, or viewing the policy in the reception area of any of RHASA's offices.

Notice of Patient Privacy Practices: RHASA's Notice of Patient Privacy Practices describes how medical information about you may be used and disclosed, and how you can get access to this information. RHASA reserves the right to change its practices regarding the protected health information it maintains. If RHASA makes changes, they will update this Notice. By my signature below, I acknowledge that I may receive the most recent copy of this Notice by visiting www.rhasa.com, requesting the Notice at any of RHASA's locations, or viewing the posted Notice in the reception area of any of RHASA's offices.

_____ _____ _____
Signature of Responsible Party Relationship to Patient Date