

**WELCOME TO OUR OFFICE**

**GENERAL INFORMATION:**

Patient's name: \_\_\_\_\_ Sex: M/F Marital Status: \_\_\_\_\_

Email: \_\_\_\_\_ Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Is interpreter needed: \_\_\_\_\_

Name of parent(s) or guardian if patient is a minor: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Emergency contact phone: (day): \_\_\_\_\_ (evening): \_\_\_\_\_

**INSURANCE INFORMATION: Please present a copy of insurance card and driver's license to receptionist.**

Primary Insurance Company: \_\_\_\_\_

Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_ Copay: \_\_\_\_\_

Insured's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_ Copay: \_\_\_\_\_

Insured's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

I hereby authorize payment be made by my insurance carriers(s) directly to the physicians of Coastal Medical Associates. I acknowledge that all above information provided is true. I acknowledge that I have been made aware of the privacy policy of this office, as it pertains to the privacy and confidentiality of my medical records.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ADDITIONAL DEMOGRAPHIC INFORMATION NEEDED**

We need your help in collecting additional demographic information for quality of care improvement and to meet objectives outlined in the "meaningful use" of Electronic Health Records released by the Department of Health and Human Services. Why are physicians being urged to collect a patient's race, ethnicity and preferred language? We are collecting this data to track quality of care, health outcomes and mortality rates by relevant groups to monitor for and address disparities as well as communicate effectively with patients.

RACE	ETHNICITY	PREFERRED LANGUAGE
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> English
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Non Hispanic or Latino	<input type="checkbox"/> Spanish
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Decline to answer	<input type="checkbox"/> Other: _____
<input type="checkbox"/> White		
<input type="checkbox"/> Other Race		
<input type="checkbox"/> Decline to Answer		

**HIPPA – PATIENT PRIVACY ACKNOWLEDGEMENT STATEMENT**

I have been given the opportunity to read and ask questions regarding the HIPPA Privacy Notice. I understand that every effort will be made to protect my private information.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> Home Telephone # _____<br><input type="checkbox"/> OK to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only<br><br><input type="checkbox"/> Work Telephone # _____<br><input type="checkbox"/> OK to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><br><input type="checkbox"/> OK to mail to my home address<br><input type="checkbox"/> OK to mail to my work<br><input type="checkbox"/> OK to fax to this number<br>_____<br><br><input type="checkbox"/> Cell Phone # _____<br><br><input type="checkbox"/> OK to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only<br><input type="checkbox"/> OK to send Text Messages related to Appointment Reminders and Confirmations |
|--|--|

I authorize my physician's staff to leave any message relating to appointment confirmation or rescheduling on my home answering machine or with a member of my household.

- I authorize my physician or physician's staff to communicate and discuss my medical health and conditions including test results with the following individuals:

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

- I do not want my medical information shared with anyone.

I agree this acknowledgement is not bound by any expiration date. I understand that this acknowledgement may only be revoked or changed by myself in writing to this office.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_




## UNIVERSAL MEDICATION FORM

<b>IMMUNIZATION RECORD</b> (Record the last dose taken)
TETANUS/TDAP:
PNEUMONIA VACCINE:
INFLUENZA VACCINE:
HEPATITIS VACCINE:

Comments:

### Patients:

1. **Always keep this form with you.**
2. Take this form to ALL doctor visits and ALL medical testing (Ia, x-ray, MRI, CT, etc.). Take this form to ALL pre-assessment visits for admission or surgery and ALL hospital visits (ER, in-patient admission, out-patient visits).
3. Update this form as changes are made to your medications. If a medication is stopped, draw a line through it and record the date it was stopped. If help is needed, ask a physician, nurse or pharmacist to help you fill out this form.

4. In the far right column, record the reason for taking the medication (high blood pressure, high blood sugar, ect.) and the name of the doctor who told you to take this medication. **Always keep this form with you.**
5. Tell your family, friends and neighbors about the benefits of using this form.
6. When you return to your doctor, take your dated form with you. **Always keep this form with you.** This will keep everyone up-to-date on your medications.

### **HOW DOES THIS FORM HELP YOU?**

#### **By using this form, it**

1. **Reduces confusion and saves time.** You do not have to remember all of the medications you are taking, the form does it for you.
2. **Improves communication.** Provides doctors, health care providers and institutions with a current list of ALL of you medications. Allows the patient and/or family member to know exactly what medications are to be taken and when.
3. **Improves MEDICATION SAFETY.** Medication interactions and duplications can be detected and corrected.