ST. ANTHONY Clinic

PATIENT DEMOGRAPHIC FORM

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

Form CONSENT
Rev. 8/19

☐ Breda	☐ Carroll	☐ Coon Rapids	☐ Manning	☐ Wall Lake	☐ Westside	☐ Denison
221 Main St.	405 S Clark St, Ste 100	215 Main St	221 Ann St	31 I West 1st St.	235 Hwy 30	1820 4th Ave S
Breda, IA 51436	Carroll, IA 51401	Coon Rapids, IA 50058	Manning, IA 51455	Wall Lake, IA 51466	Westside, IA 51467	Denison, IA 51442

PATIENT INFORMATION

Last Name: Proper First Name: Middle Initial:

Date of Birth: Social Security Number: Gender ☐M ☐F Marital Status: M S D W

Home Address: Apt # City: State: Zip Code:

Home Phone: OK to leave appt reminder at phone # provider? Y / N

Cell Phone: Email Address:

Race: Ethnicity: Language: Religion:

Interpreter: Phone #

Employer: Employer Phone: Occupation:

Employer Address: Occupation Status: (PT/FT)

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Person to Notify Relationship:

Address: City: State: Zip Code:

Home Phone: Other Phone/Cell:

Next of Kin: Relationship

Address: City: State: Zip Code:

Home Phone: Other Phone/Cell:

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

****IF YOU ARE 18 OR OLDER, YOU MUST BE YOUR OWN GUARANTOR**

Relationship to Patient ☐Self (If self - skip) ☐ Spouse ☐ Parent ☐Other

Last Name: First Name: Middle Initial:

Date of Birth: Social Security Number:

Home Address: Apt#: City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Employer: Occupation:

Employer Address: Employment Status: (FT/PT)

PATIENT'S INSURANCE INFORMATION *Please provide Insurance Card(s) to Receptionist

Primary Insurance: Subscriber: Subscriber SS#: Subscriber Relationship: Subscriber's Date of Birth:

Secondary Insurance: Subscriber: Subscriber SS#: Subscriber Relationship: Subscriber's Date of Birth:

Authorization to Release: I hereby authorize my insurance company benefits to be paid directly to St Anthony Regional Hospital whose name appears on form. I am financially responsible for non-covered services. I authorize the clinic to release any information to process this claim.

SIGNATURE: **Date:**

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PAYMENT POLICY

Co-payments are to be expected at the time services are received. We accept cash, checks, Visa, MasterCard, and Discover. All medical services provided are directly charged to the patient or responsible party. You are responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance company and will be billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with the Patient Finance Department at St. Anthony at (712) 794-5507.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By my signature below, I acknowledge that I have been provided a copy of St. Anthony Regional Hospital's Notice of Privacy Practices.

Signature: _____ **Date:** _____

NOTICE OF PATIENT RIGHTS/RESPONSIBILITIES

By my signature below, I acknowledge that I have been provided a copy of St. Anthony Regional Hospital's Patient Rights / Responsibilities.

Signature: _____ **Date:** _____

RELEASE OF INFORMATION TO FAMILY MEMBERS

I authorize the staff of St. Anthony Regional Hospital, Nursing Home and Clinics to release the information specified below.

Recipient's Name:	May be given **any** information pertinent to my care	May be given **limited** information regarding my general condition only
_____	☐	☐
_____	☐	☐
_____	☐	☐

Inpatients: This authorization is valid throughout your hospital stay unless specified otherwise. Nursing Home/Clinics: This authorization is valid for one year unless specified otherwise.

Signature: _____ **Date:** _____