St. Anthony Regional Hospital Medical Clinics

Breda Clinic	Coon Rapids	Manning	Westside	OB/GYN	Wall Lake	FCP
221 Main St.	215 Main St.	221 Ann St.	235 Hwy. 30	405 S. Clark St., Ste. 200	311 West 1st St.	405 S. Clark St. Ste 230
Breda, IA 51436	Coon Rapids, IA 50058	Manning, IA 51455	Westside, IA 51467	Carroll, IA 51401	Wall Lake, IA 51466	Carroll, IA 51401

PATIENT DEMOGRAPHIC FORM

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

Form MR.420.CFP
Rev. 04/11

PATIENT INFORMATION

Last Name | Proper First Name | Middle Initial | Maiden / Other Name

Date of Birth: | Social Security Number: | Gender M | F | Marital Status:

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

Home Phone: | Cell Phone: | Email Address:

Employer: | Employer Phone: | Occupation:

Employer Address: | Occupation Status:(PT/FT)

Race: | Language: | Religion:

Interpreter: | Phone #:

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Next of Kin: | Relationship:

Address: | City: | State: | Zip Code:

Home Phone: | Other Phone/Cell:

Person to Notify: | Relationship:

Address: | City: | State: | Zip Code:

Home Phone: | Other Phone/Cell:

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

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: | **Name of Subscriber** | **Subscribers Social Security Number:** | **Subscribers Date of Birth:**

Secondary Insurance: | **Name of Subscriber:** | **Subscriber's Social Security #** | **Subscriber's Date of Birth:**

Authorization to Release: I hereby authorize my insurance company benefits to be paid directly to St Anthony 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:** _____

PAYMENT POLICY

Co-payments are to be expected at the time services are received. We accept cash, checks, Visa, Master Card, 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 St. Anthony's Patient Finance Department (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: _____