CareSouth Carolina, Inc. Patient Demographic Sheet

MR-Demographic Form-2013-04-06

Today's Date____/____/____ Chart#:_____ Account#:_____

Patient Name:_____ Birthdate:____/____/____ Sex: □ Male □ Female
(Last) (First) (M.I)

Address:_____ Home Phone: (____)_____
(PO Box or Street) (City) (State) (Zip)

SS#:____-____-____ **VERY IMPORTANT** Cell/Other Phone: (____)_____

In Case of An Emergency, Whom Should We Call?: Name:_____ Primary Phone :(____)_____

Voter Registration: Would you like to register to vote? □ Yes □ No □ Already Registered

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other _____

Ethnicity □ Hispanic □Not Hispanic Housing: Do you have a regular place to stay at night? □ Yes □ No

Race: □ Black/African American □ White/Caucasian □ Native American/Alaska Native/American Indian □ Asian □ Native Hawaiian
□ Other Pacific Islander □ More than One Race □ Other_____

Primary Language: □ English □ Spanish □ Other_____ Migrant/Seasonal Farmworker? □ Yes □ No

Military Status □ Current Active Military □ Veteran □ No Prior Military Service □ Other:_____

Occupation:_____ Can we call you at work? □Yes □No Work Phone: (____)_____

Employer:_____ Employer Address:_____

Primary Pharmacy Name:_____ Location/City:_____

Secondary Pharmacy Name:_____ Location/City:_____

Person Responsible for Bill:

Name:_____ Birthdate:____/____/____ SS#:____-____-____
(Last) (First) (M.I)

Address:_____ Phone: (____)_____
(PO Box or Street) (City) (State) (Zip)

Primary Insured's Name:_____ Relationship:_____ SS#:____-____-____

Birthdate:____/____/____ Insured's Address:_____ Employer:_____

Insurance Company Name:_____ Insurance Phone Number: (____)_____

Policy#_____ Group#_____ Copay: $_____

Secondary Insured's Name:_____ Relationship:_____ SS#:____-____-____

Birthdate:____/____/____ Insured's Address:_____ Employer:_____

Insurance Company Name:_____ Insurance Phone Number: (____)_____

Policy#_____ Group#_____ Copay: $_____

Sliding Fee Scale Information: _____ **%** **Category:**_____ **Date:**____/____/____

AUTHORIZATION: I hereby authorize CareSouth Carolina, Inc. staff (and whomever they delegate) to provide medical, emergency and in-patient care of such treatment that may include/but is not limited to health screening, diagnoses, medical treatment, social services, and/or mental health & drug & alcohol screening, assessment, diagnoses, and treatment as is found necessary. I also authorize the release of any medical information necessary to process claims and promote continuity of care with other healthcare and enabling services. I authorize payment to be made to CareSouth Carolina, Inc. **I understand that signing this consent allows CareSouth Carolina to test me for the HIV/AIDS virus. However I may choose NOT to be tested by checking the box indicated** □ **I choose NOT to be tested for the HIV/AIDS virus.**

How did you hear about us? □ Newspaper □ Television (TV) □ Friend □ Family Member □ Health Fair □ Established Patient
□ Outreach Worker □ Staff □ Insurance Co. □ Don't Remember □ Referral _____ □ Other _____

Patient / Guardian Signature:_____ Date:____/____/____

Witnessed By:_____ Date:____/____/____

_____ _____ _____

Reviewed By: **(Should be reviewed by front office personnel at least every 6 months)**