PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

First Name:_____Middle Initial:_____Last Name:_____

Date of Birth:_____ Social Security Number:_____

Marital Status (please circle one): Single Married Other_____ Sex(Please circle one): Male Female

Street Address:_____ Phone Number:_____

City, State, Zip Code:_____ County:_____

Email Address: _____@_____

Race (please circle one): White African-American Asian Other_____
Ethnicity (please circle one): Hispanic Non-Hispanic **Veteran (please circle one): YES NO**

Please circle if one of these apply: Veteran Homeless Seasonal Worker Migrant

LEGAL GUARDIAN – *MUST be completed if patient is under the age of 18*

Parent Name/Legal Guardian:_____

Social Security Number:_____Relationship to Patient:_____

Street Address:_____ Phone Number:_____

City, State, Zip Code:_____ County:_____

HOUSEHOLD INFORMATION

Because we receive some funding to offset the costs of treating uninsured or underinsured patients, we are required to report certain demographics on all of our patients including race, family size, and income. Reporting these items assists us to receive funding to continue providing care to all of our patients. Reported information does not contain your name, address, or social security number.

Total Household Income BEFORE Taxes: (Please include **ALL** persons residing in the household)
Amount: $_____ per HOUR WEEK MONTH YEAR (circle one)
Any other income: $_____ from _____
Number in household: (including patient)_____

INSURANCE INFORMATION

Policyholder Name:_____

Primary Insurance:_____ ID#:_____ Group#:_____

Secondary Insurance:_____ ID#:_____ Group#:_____

Managed Medicaid Plan: (circle one) CARESOURCE UHC MOLINA BUCKEYE PARAMOUNT

EMPLOYER INFORMATION

Employer Name:_____ Phone#:_____

Address:_____Date of Hire:_____

PAYMENT GUARANTEE-MUST be signed!

I, _____, hereby verify that all information provided by me is true and correct to the best of my knowledge. I authorize ONE Health Ohio to make any investigation necessary to verify my eligibility for financial assistance or insurance coverage with my account. If the insurance or financial assistance information provided by me is false, I agree to pay for all services rendered (the sliding fee scale discount will be reversed to the appropriate pay status).

I consent to any services rendered to me or my dependents by the attending provider/physician. I agree to pay all fees and charges for such treatment promptly upon presentation of charges, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless disputed in writing within thirty days of billing date. I hereby authorize that my insurance benefits be paid directly to ONE Health Ohio. I realize that I am responsible to pay for all non-covered services. I also authorize the release of any pertinent medical information to insurance carriers necessary to process payment for professional services rendered by ONE Health Ohio.

Patient/Parent/Legal Guardian Signature:_____Date:_____

Staff Witness Signature:_____Date:_____