GCH Clinics
Patient Demographic Information

Patient Name: _____ Birthdate: _____ Sex ___M ___F
Social Security Number: _____ Marital Status: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

Spouse/Parent Name: _____
Spouse/Parent Employer: _____ Work Phone: _____

Emergency Contact (not at same address): _____ Phone: _____
Relationship to Patient: _____

How were you referred to us?
____ Internet _____ Phone Book _____ Friends/Family _____ Newspaper ____ Radio ____ Other _____

Insurance Information

See Copied Cards: _____
Primary Insurance Company: _____ Effective Date: _____
Primary Subscriber Name: _____ Subscriber Date of Birth: _____
Subscriber Social Security Number: _____
Insurance Group Number: _____ Insurance Policy Number: _____

Secondary Insurance Company: _____ Effective Date: _____
Primary Subscriber Name: _____ Subscriber Date of Birth: _____
Subscriber Social Security Number: _____
Insurance Group Number: _____ Insurance Policy Number: _____

Authorization

Responsible for Payment: If insurance payment of legal settlement is involved in the problem for which the patient is seeing the physician, I understand that I am personally responsible for the amount not covered by insurance or legal settlement.

Authorization for Release of Information: I hereby authorize the release of any information necessary in the course of my examination, treatment, or the process of a claim.

Authorization to Pay Benefits: I hereby authorize payment to GCH Clinics of all medical and/or surgical benefits.

Medicare Authorization: I request that payment of authorized Medicare benefits be made either to me or on my behalf to GCH Clinics for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ Date: _____

Notice of Health Information Privacy Practices

By signing below, I acknowledge that I have received a copy of the "Notice of Health Information Privacy Practices" for Guthrie County Hospital and its Organized Health Care Arrangement:

Signed: _____ Date: _____