



St James Family Medicine
Dr. Amy Forren and Dr. David Robinson

Last Name: _____ Sex: Male _____ Female _____
First Name: _____ Date of Birth: ___/___/___ Age _____ SSN: _____-_____-_____
Middle Name: _____ Preferred Name: _____
Address: _____ City: _____ County _____ State: _____ Zip: _____
Email Address: _____
Phone: Home () _____ Work () _____ Cell: () _____

Marital Status: Married Single Separated Divorced Widowed

Ethnicity: Hispanic or Latino Not Hispanic or Latino Other: _____

Primary Language: English Spanish Other: _____

Race: Caucasian African American Asian Hispanic Other: _____

Student Status: Full Part N/A School: _____ Employment: Full Part N/A Employer: _____

May we leave a voice message to remind you about appointments at your home and/or cell phone number? Yes _____ No _____

May we leave a voice message for normal test results at your home or cell phone number? Yes _____ No _____

(Complete only if you want this Practice to contact you at an alternate address or telephone number.)

Other Address: _____ City: _____ State: _____ Zip: _____ Other Phone () _____

Pharmacy Name and Phone Number: _____

Emergency Contact Name _____ Relationship _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Guarantor/Financially Responsible Person (if different from patient)

Last Name: _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ___/___/___ Age _____ SSN: _____-_____-_____

Middle: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home () _____ Work () _____ Cell: () _____

Guarantor/Financially Responsible Person's Email Address: _____

Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth: _____

Insurance Co. Phone Number: (_____) _____

Group # _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth: _____

Insurance Co. Phone Number:(_____) _____

Group # _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Ongoing Communication Regarding Your Healthcare

Referred by: _____

You must complete this section to authorize this Practice to release/discuss your health information with the following people or organizations for the following dates of service, range of time, or event(s):

From (MM/DD/YY) _____ To (MM/DD/YY) _____

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate Authorization to Release Information Form must be completed if the information being released is different than the people or organizations listed above.

Authorization, Assignment of Benefits, and Referral Medical Release

I allow this Practice to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Roper St. Francis Healthcare Notice of Information Practices, which I have been provided a copy.

I allow the release of medical information including complete medical records, test results, and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment.

I allow payment made directly to Roper St. Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and non-covered services.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informed of changes to any of my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: _____

Patient's Signature: _____

Date ____/____/____

Print Legal Guardian's Name: _____

Legal Guardian's Signature: _____

Date ____/____/____

To request restrictions of the use of your information, you must complete a separate for Request For Restrictions Form.

Office Use Only: