	Today's date:
	Referring provider:
	Primary care provider:
	Preferred pharmacy name: / Pharmacy phone:
	Pharmacy location:

PATIENT DEMOGRAPHIC INFORMATION

Patient last name:	**THIS SECTION TO BE COMPLETED BY ADULT PATIENTS ONLY**
Patient first name:	Employer name:
Patient middle name:	Employer address:
Birth date: / Age:	City: / State: / ZIP:
Address:	Employer phone:
City: / State: / ZIP:	Status:
County:	☐ Active military duty ☐ Employed, full-time ☐ Employed, part-time
E-mail:	☐ Retired ☐ Self-employed ☐ Student, full-time ☐ Student, part-time ☐ Unemployed
Phone: ☐ Mobile ☐ Land line ☐ Work	Preferred language:
Phone: ☐ Mobile ☐ Land line ☐ Work	Interpreter needed: ☐ Yes ☐ No
Gender:	Marital status:
Mother's maiden name:	☐ Married ☐ Single ☐ Other ☐ Divorced ☐ Legally separated ☐ Widowed
Last 4 digits of Social Security Number:	Religious affiliation:
Other names you may go by:	Race:
Written communication preferences (check all that apply): ☐ US Postal ☐ HealthConnect (patient portal) ☐ E-mail	☐ Black/African American ☐ White/Caucasian ☐ Asian ☐ Other ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Unknown
Verbal communication preferences (M= mobile L=Land line W=Work):	Ethnicity:
Appointments **Primary:** ☐ M ☐ L ☐ W | Secondary: ☐ M ☐ L ☐ W	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other ☐ Unknown
Clinical Message **Primary:** ☐ M ☐ L ☐ W | Secondary: ☐ M ☐ L ☐ W	☐ Other: ___
Financial message **Primary:** ☐ M ☐ L ☐ W | Secondary: ☐ M ☐ L ☐ W	

PRIMARY INSURANCE INFORMATION – We must have a copy of your insurance card to file insurance claims

Insurance company name:	
Patient relation to subscriber:	Subscriber birth date:
Subscriber last name:	Subscriber gender:
Subscriber first name:	Last 4 digits of subscriber Social Security Number:
Subscriber middle name:	Subscriber marital status:
Name on insurance card (if different):	Subscriber race:
Last: First: MI:	Preferred language:
Subscriber's policy number:	Effective date: / Co-pay:
Group name:	Subscriber address:
Group number:	City: State: ZIP:
Employer name:	Phone: ☐ Mobile ☐ Land line ☐ Work

SECONDARY INSURANCE INFORMATION (If applicable) – We must have a copy of your insurance card to file insurance claims

Insurance company name:	
Patient relation to subscriber:	Subscriber birth date:
Subscriber last name:	Subscriber gender:
Subscriber first name:	Last 4 digits of subscriber Social Security Number:
Subscriber middle name:	Subscriber marital status:
Name on insurance card (if different):	Subscriber race:
Last: First: MI:	Preferred language:
Subscriber's policy number:	Effective date: / Co-pay:
Group name:	Subscriber address:
Group number:	City: State: ZIP:
Employer name:	Phone: ☐ Mobile ☐ Land line ☐ Work

CONTACT PERSON (Next of kin or person to notify) – Unless otherwise indicated, we will not disclose information to anyone but the patient

Name (last, first, middle):	Relationship to patient:		
Phone: ☐ Mobile ☐ Land line ☐ Work	Address:		
Authorize staff to speak with contact regarding the following (check all that apply): Appointments: ☐ Mobile ☐ Land line ☐ Work Clinical Message: ☐ Mobile ☐ Land line ☐ Work Financial message: ☐ Mobile ☐ Land line ☐ Work	City:	State:	ZIP:
	Preferred language:		
	E-mail:		

GUARANTOR (Person responsible for payment and/or custodial parent – only completed if patient is under the age of 18)

Patient relationship to guarantor:			Birth date:		
Guarantor last name:			Employer name:		
Guarantor first name:			Employer address:		
Guarantor middle name:			City:	State:	ZIP:
Social Security Number:			Employer phone:		
Preferred language:			Occupation:		
E-mail:			Status: ☐ Active military duty ☐ Employed, full-time ☐ Employed, part-time ☐ Retired ☐ Self-employed ☐ Student, full-time ☐ Student, part-time ☐ Unemployed		
Address:					
City:	State:	ZIP:			
Phone: ☐ Mobile ☐ Land line ☐ Work					

AUTHORIZATION TO RELEASE AND OBTAIN MEDICAL INFORMATION

- I hereby authorize this office to release any information acquired to establish a health insurance claim form.
- I authorize this office to obtain previous medical records from other physicians and/or medical facilities.
- We may use your email address and personal information to communicate with you about a health-related product, initiative or service of Hancock Health. Also, we may use or disclose your PHI to tell you about products or services related to your treatment, case management or care coordination, preventative medicine, services or products, or alternative treatments, therapies, providers, or settings of care. Hancock Health will not share your e-mail address and personal information with any entities outside of Hancock Health. You can unsubscribe at any time to be removed from our communications. ☐ Check here to be removed from this list.
- I hereby authorize this office to release information regarding treatment of drug or alcohol abuse, psychological conditions, HIV testing or an AIDS related condition to establish a health insurance claim.
- I hereby authorize Hancock Physician Network to apply for benefits on my behalf for services rendered by him/her or his/her order.
- I request that payment from my insurance company or Medicare and Medigap be made directly to Hancock Physician Network (or the party who accepts assignment).
- I understand that I am responsible for all unpaid charges.
- I understand that all charges are to be paid at the time of service unless I present a valid insurance card that represents an insurance carrier with which Hancock Physician Network has contractual agreement. All deductibles, copays, and non-covered services are expected to be paid at the time of service.
- If my account is turned over to an outside collection agency I will be responsible for my balance plus any legal fees or collection fees involved.
- In case of children whose responsible party is someone other than the custodial parent, we must ask that the person accompanying the child to the office make payment at the time of service. Although we empathize with the problems of divorced parents we cannot become involved in the financial arrangements of the divorce decree.

Signature: ______________________________ Date: ______________

1. Does the patient have a standing DNR order? ☐ Yes ☐ No Is there a copy on file? ☐ Yes ☐ No
2. Does the patient have a living will? ☐ Yes ☐ No Is there a copy on file? ☐ Yes ☐ No
3. Does the patient have a healthcare rep.? ☐ Yes ☐ No Healthcare rep. name: ______________ Date: ______________

It is the patient's (or guarantor's) responsibility to notify the insurance company of an impending hospital or surgical admission.

1. Please provide a copy of your ID card (driver's license and insurance card).
2. Does your insurance company require precertification? ☐ Yes ☐ No
3. Does your insurance company a second surgical opinion? ☐ Yes ☐ No
4. The name and location of the laboratory your insurance company is contracted with: ______________
5. All labs will be sent to Hancock Regional Hospital Laboratory Services unless you inform us otherwise. Hancock Physician Network is not responsible for charges resulting from laboratory services processed by an incorrect laboratory. Patient's initials: ______________

HANCOCK IMMEDIATE CARE PATIENTS ONLY

If you would like the visit information from this appointment to sent to your Hancock Health primary care provider, please complete the following fields:

Provider name:	Name of practice:		
Provider address:	City:	State:	ZIP:
Provider phone:	Provider fax:		

PAYMENT AND PRIVACY ACKNOWLEDGMENT

I have received—or been offered—the Hancock Physician Network payment policy and HIPPA policy.

Signature of patient/guarantor: ______________________________ Date: ______________