PATIENT INFORMATION

FOR OFFICE USE ONLY	DATE	IDX#	MRN#

PATIENT NAME

DATE OF BIRTH	SEX ☐ MALE ☐ FEMALE ☐ OTHER	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP

HOME TELEPHONE	BUSINESS TELEPHONE	CELL NUMBER

SPOUSE'S NAME	FATHER'S FIRST NAME	MOTHER'S FIRST NAME

PLEASE PROVIDE A VALID EMAIL ADDRESS IF INTERESTED IN REGISTERING FOR MY COLUMBIA DOCTORS (SECURE WAY FOR PATIENTS TO ACCESS THEIR HEALTH INFORMATION AND COMMUNICATE WITH THE PRACTICE)

REFERRING PHYSICIAN	ADDRESS	TELEPHONE

RELIGION(OPTIONAL)	RACE(OPTIONAL)	ETHNICITY(OPTIONAL)

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION		SECONDARY INSURANCE INFORMATION	
SUBSCRIBER'S NAME		**SUBSCRIBER'S NAME**	
RELATIONSHIP TO PATIENT		**RELATIONSHIP TO PATIENT**	
HEALTH INSURANCE COMPANY		**HEALTH INSURANCE COMPANY**	
POLICY/ID NUMBER	**GROUP NUMBER**	**POLICY/ID NUMBER**	**GROUP NUMBER**

PHARMACY INFORMATION

PHARAMACY NAME	PHARMACY ADDRESS

PHARMACY TELEPHONE	PHARMACY FAX

PATIENT NOTIFICATION METHOD/APPOINTMENT REMINDERS

COLUMBIADOCTORS OFFERS PATIENTS THE ABILITY TO RECEIVE APPOINTMENT REMINDERS VIA SMS TEXT. PATIENTS THAT OPT-IN FOR THIS SERVICE WILL RECEIVE TEXT MESSAGES FOR APPOINTMENTS SCHEDULED WITH CLINICAL DEPARTMENTS. DISREGARD IF YOU HAVE OPTED-IN OR OUT PREVIOUSLY.

PLEASE NOTE: THIS SERVICE WILL ONLY BE UTILIZED FOR APPOINTMENT REMINDERS. DISCLOSURE OF LAB RESULTS AND OR TREATMENTS RELATED INFORMATION WILL NOT BE COMMUNICATED.

☐YES, I CONSENT TO RECEIVE APPOINTMENT REMINDERS VIA SMS TEXT.

PLEASE PROVIDE A VALID MOBILE NUMBER: _____

☐NO, I AM CHOOSING TO OPT-OUT OF RECEIVING APPOINTMENT REMINDERS VIA SMS TEXT.

I HEREBY ALLOW COLUMBIADOCTORS DEPARTMENT OF DERMATOLOGY TO CONTACT ME AND OR/OR LEAVE A MESSAGE ON VOICEMAIL CONTAINING PERSONAL HEALTH INFORMATION BY THE FOLLOWING METHODS:

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII (MEDICARE) OF THE SOCIAL SECURITY ACT IS CORRECT.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICAL OR SUPPLIER, ANY INFORMATION NEEDED FOR THIS OR RELATED CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT.

PATIENT'S SIGNATURE _____ DATE _____