Patient Profile

Today's Date: _________

Form can be filled out on your computer or printed and filled by hand.

Patient Information

(Please Print All Information – Thank You!)

Name:_____________________________ **Language Spoken:**_______________________

Middle Initial:____ **Date of Birth:** _________ **Race:** __________________________

Marital Status: ___*Single* ___ *Married* ___*Divorced* **Ethnicity:** __________________________

___ *Separated* ___ *Other* ___*Widowed*

Mailing Address: _______________________ **Employment Status**: ___*Retired* ___ *Unemployed*

____________________________________ ___ *Employed* ___ *Student*

City/State: ____________________ **Zip Code:** ______ **Employer/School:** ________________________

Contact Phone Numbers:

Primary (___) _______________ *Home* __ *Work* __ *Cell* __

Secondary (___) _____________ *Home* __ *Work* __ *Cell* __

Email: __________________________________

Emergency Contact

Name: _____________________________

Relationship: ________________________

Phone Number: _______________________

Gender: Male Female Non-Binary Unspecified/Indeterminate

Primary Physician: ______________________ **Referring Physician:** _______________________

LEGALLY RESPONSIBLE (GUARANTOR) INFORMATION

Same as Patient

Name: _______________________________ *Employer:* _________________________________

Address: ______________________________ *Phone: (___)* _______________________________

______________________________ *Phone: (___)* ________________________________

City/State: _____________________ *Zip Code:* ________ *Date of Birth:* ______________________

*****ONLY Fill Out The Following Section If Your Insurance Card Is NOT Present During Registration*****

PRIMARY INSURANCE *Same as Patient* *Same as Guarantor* *Other*

Insured Party: ____________________________________ *Relationship to Primary:* _______________ *Insured Phone:* ___________________

Company: __________________________ *Insured ID:* ____________________________ *Policy Group:* ___________________

Date of Birth: ____

(If you have secondary Insurance, please speak with the billing office)

Financial Agreement & Release of Information

I request, that payment of authorized Medicare or other insurance benefits be made on my behalf to Sid's Professional Pharmacy, for any services furnished to me by Sid's Professional Pharmacy. I authorize any holder of medical information about me to release to the centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I authorize the release of my personal Health Care Information that might be required for processing my insurance claims by insurance companies through which I am covered, or any subsequent insurance companies from which I obtain coverage.

Office Policy Agreement

I understand that my services will be billed to my insurance company(s) provided I have given proof of my insurance coverage at the time services are rendered. ***If I do not have proof of insurance coverage at the time services are rendered, I understand that payment is due at the time of service.*** *I will promptly pay all amounts that have been determined my responsibility by my insurance carrier within 30 days of notification.*

If I am ***over*** *the age of 18, I am ultimately responsible for any patient balance for services I have received. If I am* ***under*** *the age of 18, my parent or legal guardian is responsible for my patient balance until my 18th birthday.*

Patient Signature ___________________________________ ***Date*** _________________________

Signature of Parent/Guardian ____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

Sid's Professional Pharmacy has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and who to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact Sid's Professional Pharmacy billing office to obtain a current copy of the Notice of Privacy Practices or to ask questions.

Our ***Notice of Privacy Practices*** *describes in more detail how your health information may be used and disclosed, and how you can access your information.*

By Initialing below,

I agree I have received the Notice of Privacy Practices of Sid's Professional Pharmacy.

_________________ Patient's Initials

OFFICE USE ONLY

Form Filled Out Entirely________ (***Employee Initials***) **Copay Collected:**______________ (*Amount*)

This form will be retained in your medical record. **Collected By:** ___________ (*employee initials*)