CONWAY MEDICAL CENTER PATIENT DEMOGRAPHICS

DATE:

PATIENT INFORMATION

Patient Name	DOB	Age	Check Gender: ___M ___F
Address	Home Phone	Cell Phone	
City/State/Zip	SS#	E-Mail	
Race Religion	Highest Level of Education	Ethnicity Preferred Language	
Emergency Contact	Relationship	Emergency Phone #	
Pharmacy	Primary Care Provider Name		

PATIENT EMPLOYMENT INFORMATION

Employer	Work Number

GUARANTOR INSURANCE INFORMATION

Primary Insurance Information

Primary Insurance	Employer	Policy #	Group #
Insured Name	Address	City/State/Zip	Insured DOB Insured SS#

Secondary Insurance Information

Secondary Insurance	Employer	Policy #	Group #
Insured Name	Address	City/State/Zip	Insured DOB Insured SS#

REFERRAL INFORMATION

How did you hear about us?

PERSON AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION ABOUT YOU:

Conway Medical Center is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. Check each person that you approve to receive information.

☐ **SPOUSE** (Provide Name)

Authorized to Receive Information Regarding: _____Financial Information _____Medical Information

☐ **PARENT** (Provide Name)

Authorized to Receive Information Regarding: _____Financial Information _____Medical Information

☐ **OTHER** (Provide Name)

Authorized to Receive Information Regarding: _____Financial Information _____Medical Information

I give authorization for the release of protected health information on voicemail.

☐ Yes ☐ No

Authorized to receive information regarding:

☐ Results of tests that are normal (including but not limited to lab and x-rays)

☐ Appointment information

☐ Prescription Refill Information

☐ Other information as follows:

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Conway Mediacl Center. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

SIGNATURE OF AUTHORIZED PERSON: **DATE:**

RSK-4547-FRM
REV 0 05.07.22

School Sports Physical Consent Form

NAME:_____ DATE OF BIRTH:_____
Print First and Last Name MM/DD/YYYY

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PARENT'S/GUARDIAN'S NAME: _____

PARENT'S/GUARDIAN'S EMAIL ADDRESS:_____

PARENT'S/GUARDIAN'S PHONE NUMBER: _____

I hereby give consent for CMC providers to conduct my child's physical for participation in school sports. I understand that no treatment will be provided during said physical. If the physical reveals a condition which warrants further evaluation or treatment, I understand that a CMC provider will contact me at the provided phone number to discuss any need for referral or follow-up. I understand that I can arrange for such referral or follow-up with the provider of my choice.

Signature of Patient's Parent or Guardian:

_____

Relationship to Patient:_____