PATIENT DEMOGRAPHIC PROFILE

DATE: ________________________

How did you hear about us?: ☐ **Physician (Name)**________________ ☐ **Other Hospital or Clinic (Name)** ________________ ☐ **Friend/Family** ☐ **Billboard**

☐ **Marta Bus / Train** ☐ **Television** ☐ **Radio** ☐ **Morehouse Healthcare Website** ☐ **Other (please Specify)** ________________________________

Patient Information

Patient Name: ____ SS#________________________________ MRN__________________

D.O.B.________________________ Sex: ______________ Race: __________________ Marital Status ______________________________

Ethnicity ____________________ Preferred Language _________________

Address____ Apt. #: ______________________________

City, State: ____ Zip_______________ County________________________

Home Phone: ______________________________ Mobile: _______________________ Email:____

Primary Doctor: ____ Co-Pay Amount:__________________

Employer: _________________________________-_______________________Telephone:____

Address: ____ City, State: _______________________________________

Emergency Contact Person____ R/ship to Patient ____________________Tel: ______________

Preferred Method to be Notified: ☐ **E-mail** ☐ **Mobile Phone** ☐ **Text Messages** ☐ **Home Phone** ☐ **At Work**
Best Time to Call: ☐ **AM** ☐ **PM: Calls to remind patients about appointment will be made between 6:30pm and 7:30pm.**

Guarantor's Name (Person responsible for payment): ____Relationship to Patient________________

Guarantor's SSN: ____ Telephone #: _______________________________

Address: ____ City _________________________State: __________ ZIP: _________

INSURANCE INFORMATION:

Primary Insurance Co.: (Name/Address) ____Telephone #: ___________

Subscribers' Name: ____ SSN: _______________________________ D.O.B: ____________________

Address: ____ City: __________________________ State: __________ ZIP: ________

Subscriber #: _______________________________________ Group # or Plan:-_________________________________Effective Date:____________

Secondary Insurance Co: (Name/Address) ____Telephone #: _________________

Subscribers' Name: ____ SSN: _______________________________ D.O.B: ____________________

Address: ____ City: __________________________ State: __________ ZIP: ________

Subscriber #: _______________________________________ Group # or Plan:-_________________________________Effective Date:____________

AUTHORIZATION: I hereby authorize my insurance, Medicare and /or Medicaid benefits to be paid directly to Morehouse Healthcare, Inc. I understand that I am financially responsible for any balance. I also authorize Morehouse Healthcare, Inc. to release any information requested to process my claim.

Signature: ____ Date: ______________________________________

Revised 4/1/14

PHARMACY INFORMATION:

Local Pharmacy Name ____

Location of Pharmacy: ____ Telephone #: ____________________

Mail Order Pharmacy (if you use one): _________________________________ Telephone #:____________________

ADVANCE DIRECTIVES:

Do you have a donor card? _____ Yes ______ No

Do you have a living will? _____Yes _______No

(A living will is a written document that allows you as a competent adult to indicate your wishes regarding life prolonging medical treatment, in the event that you become incapacitated).

Do you have a Durable Power of Attorney for Healthcare? ______Yes _____No

(A durable Power of Attorney for Healthcare allows you to select an adult to make medical decisions for you).

CONSENT FOR TREATMENT

I grant Morehouse Healthcare permission to provide any medical treatment considered necessary by a clinical provider.

I understand that all treatment is voluntary and that I may cease treatment at any time.

____________________________	____________	________________________________	_________
Patient Signature	Date	Parent/Legal Guardian	Date

Revised 4/1/14