

New Patient Demographic Form

Do NOT complete this page if you have previously provided this information to ColumbiaDoctors.

Patient Information

Last Name: _____ First Name: _____ MI: _____
Date of Birth: ____ / ____ / ____ Gender: _____
Home Address: _____ City, ST: _____ Zip: _____
Home Phone: _____ Other Phone: _____ Preferred: Home Other
Patient Email Address: _____ Marital Status: _____

Guarantor/Parent: _____ Date of Birth: ____ / ____ / ____
Address: _____ City, ST: _____ Zip: _____
Phone: _____ Relationship to Patient: _____

Emergency Contact (if other than guarantor): _____
Emergency Phone: _____ Relationship to Patient: _____

Insurance Information

Insurance Company Name: _____
Insurance Address: _____ City, ST: _____ ZIP: _____
Certificate/Plan/ID #: _____ Group (Grp): _____
Subscriber (if other than patient or guarantor): _____
Subscriber Address: _____ City, ST: _____ ZIP: _____
Subscriber Date of Birth: ____ / ____ / ____ Relationship to Patient: _____

Please present a copy of your insurance card/information, if available, when you return this form.

Patient Employment Information

Employer: _____ Occupation: _____
Employer Address: _____ City, ST: _____ Zip: _____
Patient Work Phone: _____

myColumbiaDoctors Patient Portal Sign Up

Access your personal records securely, 24/7, on a computer, smartphone, or iPad. See brochure for details.

Send me an invitation to join myColumbiaDoctors.

Look for your email invite to register from noreply@followmyhealth.org and click the registration link.

Last Name: _____ First Name: _____ DOB: ____ / ____ / ____

Please provide information regarding your health care providers in the spaces below:

	Name	Phone	Location	Date of last visit
Primary Care				/ /
Psychiatrist				/ /
Psychotherapist				/ /
Dentist				/ /

Preferred Pharmacy: _____ Pharmacy Phone: _____
 Preferred Pharmacy Address: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

- Ethnicity: Decline Response Hispanic or Latino Not Hispanic or Latino
- Race: Decline Response American-Indian or Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander White Other

Preferred Language: _____ Decline Response
 Patient Signature: _____ Date: _____

Patient Financial Obligation Agreement- UHC Columbia

I understand that all applicable copayments and deductibles may be collected upon check-in for each visit. I agree to be financially responsible and make full payment for all charges not covered by my insurance. I authorize my insurance benefits to be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____
 Patient or Guarantor Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices.

Patient Name (Print): _____
 Patient Signature: _____ Date: _____

If completed by a patient's personal representative, please print and sign below.

Representative (Print): _____ Relationship: _____
 Representative Signature: _____ Date: _____