PNS-9061-FRM
REV 1 3.28.24

CONWAY MEDICAL CENTER PATIENT DEMOGRAPHICS

Today's Date

PATIENT INFORMATION

Patient Name	Date of Birth	Age

Address	Home Phone	Cell Phone

City/State/Zip	SS#	E-Mail

Gender Identity (please circle or write)
Male Female Transgender[M TO F] Transgender[F TO M] Refuse Other:

Sexual Orientation (please circle or write)
Heterosexual Homosexual Other:

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 Medical 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:**