STAMFORD HEALTH
Healing. Reimagined.

Affiliate Columbia University College of Physicians and Surgeons
Member NewYork-Presbyterian Healthcare System
A Planetree Hospital

# Patient Information Form

**Please provide all requested information and be sure to sign form. PLEASE PRINT**

Last Name _____ First Name _____Middle Initial _____

Home Address_____
Street City State Zip Code

Home Phone _____Cell Phone _____Work Phone_____

Best number to call or leave a message: (Please check one) ❒Home ❒Cell ❒Work

Date of Birth _____ Marital Status _____ Sex ❒Male ❒Female

Email _____Would you like to register for the Patient Portal? ❒Yes ❒No

Referring Doctor _____ Primary Care Dr. _____
First and last name First and last name

**Please list your other healthcare providers below. Please request an additional form if you have more than five providers.**

| Provider's Full Name | Specialty | Address and/or Phone # |
|---|---|---|
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**Based on government guidelines we are required to ask you race, ethnicity and preferred language. This information will be used to help monitor quality and improve patient care.**

**Race:** (please check one)
❒Asian ❒Black/African American ❒Hispanic ❒Native Hawaiian/Pacific Islander ❒White
❒Refused to report ❒other _____

**Ethnicity:** (please check one)
❒Hispanic or Latin ❒Not Hispanic or Latin ❒Refused to report

**Preferred Language:** (please check one)
❒English ❒French ❒Italian ❒Spanish ❒Refused to report ❒other _____

**Preferred Pharmacy Information**

Name _____ Street, City and State _____

**Rx History Consent**
I give permission for my physician to access my historical prescription information. ❒Yes ❒No

**Emergency Contact:** Name _____ Phone # _____Relationship _____

**Primary Insurance Information – *this must be completed even if we copy your card.***

Insurance Company Name: _____

ID#:_____ Group#: _____ Subscriber: _____ Subscriber DOB:_____

Relationship to patient: _____Employer of Subscriber:_____

**Secondary Insurance Information** (if applicable)

Insurance Company Name: _____

ID#:_____ Group#: _____ Subscriber: _____ Subscriber DOB:_____

Relationship to patient: _____Employer of Subscriber:_____

**Financial Responsibility**
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

**Assignment of Benefits**
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Stamford Health Medical Group for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

**Authorization to Release Information**
I hereby authorize Stamford Health Medical Group to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Stamford Health Medical Group on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

Stamford Health Medical Group reserves the right to terminate the Practice-Patient relationship under certain circumstances including, but not limited to, patient misconduct and recurrent no-shows pursuant to our practice policy.

I further understand that cost shares assigned by my insurance carrier are due and payable at the time of service such as copays, deductibles, coinsurance and payment for non- covered services unless prior arrangements have been made.

Patient/Responsible Party Signature _____
Date: _____