

Davis Square Family Practice

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Background Information

Name _____ Gender _____

Address _____ City _____ State _____ Zip Code _____

Home Telephone _____ Work Telephone _____

Mobile Telephone _____ Email _____

Date of Birth _____ Social Security Number _____

Marital Status: S M D W Other: _____ Spouse/Partner's name: _____

Children: Names, Ages, Health Concerns (physical/developmental/social) _____

Occupation: _____ Employer: _____

Allergies: _____

Emergency Contact

Name/Phone#: _____ Relation _____

Pharmacy

Name/Phone#: _____ City/State: _____

Prescription History Authorization

I grant permission to Davis Square Family Practice to view my prescription history from external sources. **Yes No**

Insurance Information

Primary Insurance: _____ Policy Number: _____

Subscriber is (circle one) Self Spouse Mother Father Other _____

REQUIRED: Date of birth of subscriber (if not patient) _____

Subscriber's Name (if not patient) _____

Secondary Insurance (if applicable) _____ Policy Number: _____

Insurance Waiver and Release

I authorize Davis Square Family Practice to furnish any medical information to my insurance carrier(s) concerning myself or my dependents for the purpose of coordination of medical care or benefit determination. I authorize Davis Square Family Practice to receive all payments for medical services rendered to myself or my dependents. I understand I am financially responsible for all amounts uncovered by the insurance carrier(s) and any co-pay due at the time of the visit.

Signature: _____ Date: _____

Self Pay Agreement

I understand that I am financially responsible to pay for any charges incurred by myself or my dependents for medical services provided by Davis Square Family Practice.

Signature: _____ Date: _____

(OVER)

Race: American Indian or Alaskan Native Asian Native Hawaiian Other Pacific Islander
 Black or African American White Choose Not to Answer

Ethnicity: Hispanic Non-Hispanic Choose Not to Answer

Preferred Language:

English Spanish Russian Armenian Portuguese Korean Italian Greek
 Chinese-Mandarin Other

I acknowledge that Davis Square Family Practice has provided me with a copy of *Rules Concerning the Privacy of Your Medical Information* regarding *Protected Health Information* created, received or stored by Davis Square Family Practice. My questions have been answered satisfactorily and I understand this notice.

Signature _____ Date _____

Why are you asking me my race, ethnicity, and preferred language?

This information is required under new legislation from the U.S. Department of Health and Human Services (HHS). With the ongoing transition to electronic health records, HHS and our providers will be better able to assess this demographic data in a meaningful way. The goals of these initiatives include improving patient safety and overall healthcare quality. Additionally, we hope to be able to indentify health disparities and better understand and serve all of all patients.

Why are you asking for my email address?

We are now offering our patients easy and private access to their medical information online, so you can view your personal health record whenever and wherever you have access to the internet. You will have access to appointment dates, lab results, x-ray and diagnostic imaging, personal health record and health maintenance reminders. You will also be able to send messages to clinical staff.

**You will only be asked for this information once by this office, and
you have the right to decline answering these questions.**