# Davis Square Family Practice

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## Background Information

**Name**_____ **Preferred Name:**_____ **Sex:** ☐Male ☐Female

**I identify my gender as:** ☐Male ☐Female ☐Transgender/M to F ☐Transgender/F to M ☐Choose Not to Disclose

Prefer to Self-Describe:_____ **Preferred Pronouns:**_____

**Sexual Orientation:** ☐Straight ☐Lesbian or Gay ☐Bisexual ☐Something Else ☐Unsure ☐Choose Not to Disclose

**Address:** Street _____ City_____ State_____ Zip Code_____

**Home Telephone:**_____ **Mobile Telephone:**_____ **Email:**_____

**Date of Birth:**_____ **Social Security Number:**_____

**Marital Status:** ☐Single ☐Partner ☐Married ☐Divorced ☐Widowed ☐Other Spouse/Partner's name: _____

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

_____

**Employment Status:** ☐Full Time ☐Part Time ☐Self Employed ☐Per Diem ☐Not Employed ☐Disabled
☐On Active Military Duty ☐Student Full Time ☐Student Part Time ☐Volunteer

**Occupation:**_____ **Employer:**_____

**Allergies:**_____

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

**Pharmacy**
Name:_____ City/State:_____ Phone #:_____

**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: ☐Self ☐Spouse ☐Parent:_____ Other_____

**REQUIRED:** Subscriber's Name(if not patient)_____ Date of Birth of Subscriber:_____

Secondary Insurance (if applicable)_____ Policy Number:_____

**Insurance Waiver and Release/ Self Pay Agreement**

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. 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:**_____

**(PLEASE TURN PAGE OVER)**

**Race:** ☐African American ☐Alaskan Native ☐American Indian ☐Asian ☐Black ☐Native Hawaiian ☐Pacific Islander ☐White ☐Other Race ☐Choose Not to Disclose

**Hispanic/Latino:** ☐Hispanic ☐Non-Hispanic ☐Choose Not to Disclose

**Ethnicity:** _____ ☐Chose Not to Disclose
(e.g. Irish, Portuguese, African, Asian, Egyptian, Czech, Mexican, etc.)

**Primary Written Language:**_____ **Religion:** _____

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.**