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BOUNDARY Community Clinics
a division of Boundary Community Hospital
boundarycommunityhospital.org/clinics

PATIENT INFORMATION

_____ _____ _____ _____ _____
Last Name First Name Middle Previous Last Name Date of Birth

Social Security #_____ Male/Female (Circle) Phone: _____ County: _____

_____ _____
Mailing Address City State Zip Code

_____ _____
Physical or Secondary Address City State Zip Code

Race (please check one)
_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or other Pacific Islander
_____ White/Caucasian
_____ Multi-Racial
_____ Other: _____
_____ Decline to Answer

Language (please check one)
_____ American Sign Language
_____ English
_____ French
_____ German
_____ Japanese
_____ Mandarin – Cantonese
_____ Mandarin – Chinese
_____ Russian
_____ Somali
_____ Spanish
_____ Vietnamese
_____ Other: _____

Do you consider yourself to be of Hispanic or Latino ethnicity? (please check one) _____ NO _____YES _____ Decline to answer

Marital Status (please check one)
_____ Single
_____ Married
_____ Divorced
_____ Widowed

Student Status (please circle one)
_____ Full time
_____ Part time
_____ Not a Student

Are you a veteran? _____No _____ Yes

Do you smoke? _____No _____ Yes

Primary Care Provider _____ Referring Provider _____

Contact Information
Home Phone _____ Cell Phone _____
Day Phone _____ E-mail Address _____
Alternate/Emergency Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____ Self-Pay _____
**Please provide insurance card(s) for photocopying

_____ _____ _____
Employer Employer Address Employer Phone Number

Preferred Pharmacy _____ Location _____ Phone _____

To the best of my knowledge, all of the above information is true and complete. I authorize payment of insurance benefits to be paid directly to Boundary Community Clinics and I understand that I am responsible for any health insurance deductible, co-payment and/or co-insurance and will make specific arrangements to pay balances not covered by insurance on a timely basis. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and collection costs. I grant permission to my providers to mutually exchange medical information as outlined in the privacy policy of this organization.

Signed _____ Date _____

PRIVACY NOTICE ACKNOWLEDGEMENT

As a patient of Boundary Community Clinics, I understand that under the Health Insurance Portability & Accountability Act of 1966 ("HIPAA") I have certain rights to privacy regarding my protected health information. I have been informed of the posted location of the clinic's Notice of Privacy Practices and offered a copy of the notice. I understand that Boundary Community Clinics has the right to change the notice from time-to-time and that I may contact my physician's office at any time to request a current copy of the notice

I understand that I may request in writing that Boundary Community Clinics restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Boundary Community Clinics is not required to agree to my requested restrictions, but if restrictions are agreed to, then Boundary Community Clinics is bound to abide by such restrictions.

Patient Name (please print) _____

Patient Signature: _____

Relationship (If other than patient) _____

PATIENT COMMUNICATION AUTHORIZATION

I, _____, wish to be contacted in the following manner (check all that apply):

_____ Home Telephone Number: _____

- _____ OK to leave message with detailed information
- _____ Leave message with callback number only

_____ Work Telephone Number: _____

- _____ OK to leave message with detailed information
- _____ Leave message with callback number only

_____ Written Communication

- _____ OK to mail to my home

_____ No restrictions necessary

I, _____, authorize Boundary Clinics to disclose information to:

Spouse _____ Phone Number: _____
Child _____ Phone Number: _____
Parent _____ Phone Number: _____
Caregiver/Other _____ Phone Number: _____

Additional Comments: _____
_____
_____.

Signed: _____ Date: _____