STAMFORD HEALTH
Healing. Reimagined.

Affiliate: Columbia University College of Physicians and Surgeons
A Planetree Hospital
A Magnet® Recognized Hospital

Patient Information Form

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

Last Name _____ First Name _____Middle Initial ___

DOB_____ Sex ❒M ❒F ❒T

Home Address_____
Street City State Zip Code

Home Phone _____Cell Phone _____Work Phone_____

Parent Name _____DOB _____ Cell phone_____

Parent Name _____DOB _____Cell phone_____

Mother's maiden name_____ Primary Care Dr _____

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

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 #

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

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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: _____