

2012 Patient Demographic Information Form

(Once completed please return this to check-in along with your insurance card & picture ID so that it may be scanned into our system)

Date: _____

Greenway Account Number: _____

Preferred Provider (Please Circle Only One - Does not have to be the provider you are seeing today)

Dr. Gaines Dr. Corvin Dr. Gunter Dr. Anya Dr. Placide Dr. Anderson Dr. Huffman
Donna Robertson, WHNP Karen Hilbert, WHNP

Demographic Information

Legal Name First: _____ Middle: _____ Last: _____

Preferred Name: _____ Maiden Name: _____

Prefix (Please Circle): Dr Miss Mr Mrs Ms Credentials: _____

Date of Birth: _____ Place of Birth: _____ Soc. Sec #: _____

Street Address (Must be physical address - No PO Boxes): _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

*****Effective April 1, 2012 - Residents of Central North Carolina who use the 919 area code will have to dial 10-digit telephone numbers when placing Local Calls - The N.C. Utilities Commission will add the 984 area code to the region that is now only covered by the 919 area code. Due to this change it is imperative that you give us your entire phone number including area code for each of your number you give us since the last 7 digits will be duplicated and someone may have the same phone number as you, but just a different area code.*****

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Phone Number (Please Circle): Home Work Cell

Education: _____ Occupation: _____

Employer: _____

Fax Number: _____ E-Mail Address: _____

Preferred Method of Communication (Please Circle): E-mail Fax Mail Phone Text

Race (Please Circle): American Indian/Alaska Native Asian Black/African American Decline
Native Hawaiian/Pacific Islander Other Race White

Ethnicity(Please Circle): Decline Hispanic/Latino Non-Hispanic/Non-Latino

Primary Language: _____ If English is not primary, is an interpreter available: _____

Marital Status (Please Circle): Divorced Married Other Separated Single Widowed

Spouse/Domestic Partner/Parent Name (Only list parent information in the others do not apply): _____

Date of Birth: _____ Place of Birth: _____ Soc. Sec #: _____

Education: _____ Occupation: _____

Employer: _____ Work #: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referred to Office by: _____

Over for additional information

Patient Pharmacy Information

Preferred Pharmacy Name: _____ Pharmacy Phone Number: _____

Address (Street Address/Intersection): _____

Insurance Information

(Please complete the below information and also present your current card(s) to the receptionist when returning the completed form)

Insurance (Primary): _____ Policy Holder: _____

Policy Holder SS# _____ Policy Holder DOB: _____

Policy Number: _____ Group: _____

Insurance (Secondary): _____ Policy Holder: _____

Policy Holder SS# _____ Policy Holder DOB: _____

Policy Number: _____ Group: _____

If Medicare is Secondary, Why? Working Age Spouse Employed Disabled Other (Please Explain): _____

PLEASE READ AND SIGN BELOW AUTHORIZATIONS

AUTHORIZATION TO PAY PHYSICIAN: I hereby authorize payments directly to the physician for Medical Benefits, if any, otherwise payable to me for services as described, realizing that I am responsible to pay for all non-covered services.

Patient's Signature (Parent or guardian if patient is a minor)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in the course of my treatment which is necessary to process my insurance claims.

Patient's Signature (Parent or guardian if patient is a minor)

PLEASE INITIAL BESIDE EACH LINE TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND EACH OF THE SECTIONS OF OUR FINANCIAL POLICY.

By initialing you are stating that you have read that particular section of the policy and understand all information stated.

- _____ Updating Information
- _____ Medicare
- _____ Appointments
- _____ Insurance Information
- _____ Co-Pays, Co-Insurance & Deductibles
- _____ Past Due Accounts
- _____ Prescriptions for UTI and/or Vaginitis
- _____ Annual Exams vs. Problem Visits
- _____ Insurance Claims, Coding & The Law