New Patient Intake Form

Do NOT complete this page if you have previously provided this information to ColumbiaDoctors.

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Gender: _____

Home Address: _____ City, ST: _____ Zip: _____

Home Phone: _____ Other Phone: _____ Preferred: Home Other

Patient Email Address: _____ Marital Status: _____

Guarantor/Parent: _____ Date of Birth: ____/____/____

Address: _____ City, ST: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

Emergency Contact (if other than guarantor): _____

Emergency Phone: _____ Relationship to Patient: _____

Insurance Information

Insurance Company Name: _____

Insurance Address: _____ City, ST: _____ ZIP: _____

Certificate/Plan/ID #: _____ Group (Grp): _____

Subscriber (if other than patient or guarantor): _____

Subscriber Address: _____ City, ST: _____ ZIP: _____

Subscriber Date of Birth: ____/____/____ Relationship to Patient: _____

Please present a copy of your insurance card/information, if available, when you return this form.

Patient Employment Information

Employer: _____ Occupation: _____

Employer Address: _____ City, ST: _____ Zip: _____

Patient Work Phone: _____

Text Messaging Agreement

□ I consent to receive messages from ColumbiaDoctors for my healthcare services at the phone number(s) above, and my wireless (fill in) _____. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

□ Opt out

myColumbiaDoctors Patient Portal Sign Up

Access your personal records securely, 24/7, on a computer, smartphone, or iPad. See brochure for details.

□ Send me an invitation to join myColumbiaDoctors. □ Opt out

Look for your email invite to register from noreply@followmyhealth.org and click the registration link.

Last Name: _____ First Name: _____ DOB: / /

Please provide information regarding your health care providers in the spaces below:

	Name	Phone	Location	Date of last visit
Primary Care				/ /
Psychiatrist				/ /
Psychotherapist				/ /
Dentist				/ /

Preferred Pharmacy: _____ Pharmacy Phone: _____

Preferred Pharmacy Address: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- □ Decline Response
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Race:

- □ Decline Response
- □ American-Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Pacific Islander
- □ White
- □ Other

Preferred Language: _____ □ Decline Response

Patient Signature: _____ Date: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles may be collected upon check-in for each visit. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____

Patient or Guarantor Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

If completed by a patient's personal representative, please print and sign below.

Representative (Print): _____ Relationship: _____

Representative Signature: _____ Date: _____