CENTRAL OHIO PRIMARY CARE
THE BEST FOR PRIMARY CARE

PATIENT DEMOGRAPHIC INFORMATION – ADULT

Please Complete This Entire Form. Thank You!

Today's Date: _____/_____/____ **Referred By *(If Applicable)*: _____**

PATIENT INFORMATION

OFFICE USE (P#):

LAST NAME:	**LEGAL FIRST NAME:**	**MIDDLE INITIAL:**	**DATE OF BIRTH *(mm/dd/yyyy)*:**
MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHYSICAL ADDRESS *(If different from mailing address)*:	**CITY:**	**STATE:**	**ZIP:**
HOME PHONE: ( )	**CELL PHONE:** ( )	**WORK PHONE:** ( )	**EXTENSION:**
E-MAIL ADDRESS: □ None □ Prefer Not To Disclose	**USE E-MAIL ADDRESS FOR PATIENT PORTAL:** □ Yes □ No □ Not Applicable	**SOCIAL SECURITY # *(If applicable)*:**	
Birth Gender: □ Male □ Female □ Unknown	**Sexual Orientation:** □ Heterosexual □ Homosexual □ Bi-sexual □ Do not know □ Decline to Disclose □ Other	**Gender Identity:** □ Decline to Disclose □ Male □ Female □ Genderqueer/Non Binary □ Male to Female Transgender □ Female to Male Transgender □ Other:	
RACE: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Native Hawaiian/ Other Pacific Islander □ White □ Decline to Specify □ Other		**Marital Status:** □ Single □ Married □ Separated □ Divorced □ Partner □ Widowed	
ETHNICITY: □ Hispanic/Latin □ Non-Hispanic/Latin □ Decline to Specify		**PREFERRED LANGUAGE:** □ English □ Spanish □ Other *(Specify)*:	

EMERGENCY CONTACT

LAST NAME:	**FIRST NAME:**	**RELATIONSHIP *(Please specify)*:**
HOME PHONE: ( )	**CELL PHONE:** ( )	**MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL:** □ Yes □ No

ADDITIONAL CONTACT #1(OPTIONAL)

LAST NAME:	**FIRST NAME:**	**RELATIONSHIP *(Please specify)*:**
HOME PHONE: ( )	**CELL PHONE:** ( )	**MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL:** □ Yes □ No

EMPLOYER INFORMATION

EMPLOYER NAME:	**EMPLOYER PHONE NUMBER:** ( )
EMPLOYMENT STATUS: □ Full Time □ Part Time □ Retired □ Self Employed □ Unemployed □ Active Military □ Student □ Unknown	

INSURANCE INFORMATION *(Please present all current insurance cards to the Front Desk)*

I HAVE INSURANCE: □ Yes □ No *(Self Pay)*			
PRIMARY INSURANCE:		**SECONDARY INSURANCE:**	
SUBSCRIBER:	**RELATION:**	**SUBSCRIBER:**	**RELATION:**
GENDER: □ Male □ Female □ Transgender □ Unknown		**GENDER:** □ Male □ Female □ Transgender □ Unknown	
DATE OF BIRTH *(mm/dd/yyyy)*:	**SOCIAL SECURITY #:**	**DATE OF BIRTH *(mm/dd/yyyy)*:**	**SOCIAL SECURITY #:**

CONFIDENTIAL COMMUNICATION *(I hereby request to receive confidential communications from COPC in the following manner)*

TELECOMMUNICATIONS –Please leave messages regarding my protected health information as follows (*Check All That Apply*):

□ Home Phone of Record □ Brief □ Extended
□ Cell Phone of Record □ Brief □ Extended
□ Work Phone of Record □ Brief □ Extended

POSTAL COMMUNICATIONS –Please mail my protected health information to me at (*Select Only One*):

□ Mailing Address of Record □ Street Address of Record
□ Other:

_____
Street Address City State Zip

ADVANCE DIRECTIVES

DO YOU HAVE A LIVING WILL?	□ No □ Yes	*(If yes, please provide a copy to the Front Desk)*
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?	□ No □ Yes	*(If yes, please provide a copy to the Front Desk)*
DO YOU HAVE A DO NOT RESCUSITATE?	□ No □ Yes	*(If yes, please provide a copy to the Front Desk)*

HOW DID YOU HEAR ABOUT US?

□ Internet Search □ Health Plan Website □ Facebook □ Referred from Family Member/ Friend □ Online Reviews □ Print Advertisement
□ Television Advertisement □ Radio Advertisement □ COPC Website □ COPC Concierge Line □ Referred by COPC Physician (Name)_____
□ Referring Physician □ Outdoor/ Billboard Advertising □ Community Event □ Other_____

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

Receipt of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices at COPC which outlines my privacy rights and how COPC may use and disclose Protected Health Information about me.

□ Yes □ No □ Offered but Decline Initials: _____

Photograph for Patient Identification

I give my consent to the use of my photograph for identification on my electronic health record. **□ Accept □ Decline Initials: _____**

Telephone Contacts, Monitoring and Recording-this does not include calls related to appointments, billing or health-related information

I hereby consent and agree that: (1) any calls with COPC may be monitored and/or recorded and that COPC (or anyone acting on COPC's behalf) may contact me, from time to time, regarding my account (including for collections purposes or related to insurance coverage) or regarding my most recent visit with my provider; (2) any and all of COPC's contacts with me may be made via text message or with an automated dialing device; (3) COPC may contact me at any telephone number I provide to them, whether a residential, business number, or mobile number; (4) COPC may e-mail newsletters informing me of new services or suggested health screenings; and (5) I have an established business relationship with COPC and COPC may contact me in any of the ways described above. I understand that, if I accept now, I may opt-out at any time by notifying the COPC EHR Department.

□ Accept □ Decline Initials: _____

Health Information Exchange (HIE)

COPC participates in one or more Health Information Exchanges that share medical information to facilitate improved care through a comprehensive health record. This information is secure and only available to those providers involved in your care delivery. I agree that my COPC provider may allow access to my health information through the Health Information Exchange for treatment or other health care operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying the COPC EHR Department or my physician.

All COPC patients are automatically enrolled in the HIE unless the Opt-Out box is checked and initialed. **□ Opt-Out Initials: _____**

Confidential Communications

I understand COPC will notify me if COPC is unable to comply with my request for Confidential Communications.

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

Insurance Assignment and Acknowledgement

I understand my insurance carrier can choose to assign benefits to COPC or my Insurance carrier may make a payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information.

***Medicare and Medicaid:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.*

I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment. I certify that I will pay to COPC any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to COPC any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by my insurance for my failure to provide the appropriate insurance information for billing.

General Consent for Treatment

I have selected Central Ohio Primary Care Physicians, Inc. as my medical provider. I am presenting to COPC, and I consent to the services, treatments, and procedures performed and ordered by my physician(s) and other healthcare providers, which may be performed during an episode of care, including, but not limited to, those rendered in person and via electronic means such as telemedicine. I acknowledge that medicine is not an exact science, my diagnosis and treatment may involve risk of injury or even death, and no guarantees can be made to me as to the results of examinations or treatments during any episode of care, and I elect to receive Services with full understanding of this information and these potential risks.

By signing below, I am acknowledging that I have read and understand the above statements.

_____	_____	_____
Patient Printed Name	**Patient Signature**	**Date Signed**
_____	_____	_____
Legal Guardian Printed Name (*if applicable*)*	**Legal Guardian Signature (*if applicable*)***	**Date Signed**

PLEASE PROVIDE A COPY OF LEGAL GUARDIANSHIP COURT PAPERS FOR THE PATIENT'S RECORD.

Adult: 12/2/15, 1/27/16, 3/22/16, 2/11/19, 11/21/19, 1/23/2020, 3/12/2020