PATIENT INTAKE

Raphael Health Center

PATIENT NAME	BIRTHDAY	SOCIAL SEC #	SEX: M F
CURRENT ADDRESS			

STREET CITY STATE ZIP

CELL PHONE ( )	HOME PHONE ( )	WORK PHONE ( )
ALTERNATE PHONE ( )	E-MAIL:	

☐ Use this email address to sign up for the Raphael Patient Portal

PHARMACY NAME:	ADDRESS:	PHONE ( )

REFERRING M.D.	PHONE ( )	FAMILY M.D.	PHONE ( )

IS PATIENT CURRENTLY IN A SKILLED NURSING FACILITY OR HOSPICE CARE?	Y N
NAME OF HOSPICE OR NURSING FACILITY?	PHONE ( )
EMERGENCY CONTACT NAME:	PHONE ( )

EMERGENCY CONTACT RELATION: ☐ SPOUSE ☐ PARENT ☐ RELATIVE ☐ LEGAL GUARDIAN ☐ FRIEND

PATIENT INFORMATION

Ethnic Identity*:	Please check (✓) One:		Gender Identity	Please check (✓) One:
Hispanic/Latino			Male	
Not Hispanic/Latino			Female	
Choose not to disclose			Transgender: Male to Female	
Race:	Please check (✓) One:		Transgender: Female to Male	
Caucasian			Other	
Black			Choose not to disclose	
American Indian or Alaskan Native			Sexual Orientation*:	Please check (✓) One:
Native Hawaiian/Pacific Islander			Lesbian or Gay	
Asian			Straight / Heterosexual	
Multiracial: More than 1 race			Bisexual	
Choose not to disclose			Something Else	
Primary Language:	Please check (✓) One:		Don't know	
English			Choose not to disclose	
Spanish				
Other:				

*This data is collected to improve health outcomes by providing culturally competent care and reducing health disparities.

Home:	Please check (✓) One:		Marital Status:	Please check (✓) One:
Own/Rent			Single	
Staying with others			Married	
Shelter			Separated	
Homeless as of (date)			Divorced	
Public Housing			Widowed	
Veteran:			Student Status:	
Yes			Full Time	
No			Part Time	

INCOME

EMPLOYMENT					
☐ NONE	☐FULL TIME	☐ PART TIME	☐ SEASONAL	☐ RETIRED	☐ AGRICUTURAL WORKER

OCCUPATION:			EMPLOYER:			
PATIENT'S GROSS INCOME:	$	☐ WEEKLY	☐ BI -WEEKLY	☐ MONTHLY	☐ ANNUALLY	☐ Unknown
NUMBER LIVING IN THE HOME:						

PATIENT INTAKE

Raphael Health Center

GUARANTOR
RESPONSIBLE PARTY (GUARANTOR) NAME:

(Person Responsible for Payment)

RELATIONSHIP TO PATIENT: ☐ SELF ☐MOTHER ☐ FATHER ☐ GUARDIAN ☐ OTHER
ADDRESS:

STREET CITY STATE ZIP

PHONE:	SOCIAL SEC. #:	BIRTHDATE:

INSURANCE INFORMATION	
PRIMARY COVERAGE	**SECONDARY COVERAGE**
NAME OF INS. CO.	NAME OF INS. CO.
POLICY HOLDER NAME: DOB:	POLICY HOLDER NAME: DOB:
PATIENT RELATIONSHIP TO POLICYHOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD OTHER:	PATIENT RELATIONSHIP TO POLICYHOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD OTHER:
MEMBER ID #:	MEMBER ID #:
GROUP #:	GROUP #:
EFFECTIVE DATE:	EFFECTIVE DATE:

MEDICARE MEDIGAP RELEASE:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND MEDIGAP BENEFITS BE MADE ON MY BEHALF TO THE PHYSICIANS OF RAPHAEL HEALTH CENTER FOR ANY SERVICES THEY PROVIDE TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

INSURANCE RELEASE/PATIENT RESPONSIBILITY:

I HEREBY AUTHORIZE RAPHAEL HEALTH CENTER TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES RENDERED TO ME BY RAPHAEL HEALTH CENTER PROVIDERS OR BY THEIR ORDERS.

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF TO RAPHAEL HEALTH CENTER FOR ANY SERVICES PROVIDED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME, TO RELEASE, TO THE INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION ACQUIRED TO ESTABLISH A HEALTH INSURANCE CLAIM. I AUTHORIZE THIS OFFICE TO OBTAIN PREVIOUS MEDICAL RECORDS FROM OTHER PHYSICIANS AND/OR MEDICAL FACILITIES, INCLUDING BUT NOT LIMITED TO INFORMATION REGARDING TREATMENT OF DRUG OR ALCOHOL ABUSE, PSYCHOLOGICAL CONDITIONS, HIV TESTING OR AN AIDS RELATED CONDITION.

I UNDERSTAND THAT I MAY BE PERSONALLY RESPONSIBLE FOR ALL CHARGES INCLUDING DEDUCTIBLES, CO-PAYS, NON COVERED SERVICES AND ANY AMOUNT NOT COVERED BY MY INSURANCE (EXCEPT IN CASES OF A CONTRACTUAL AGREEMENT BETWEEN MY INSURANCE CARRIER AND RAPHAEL HEALTH CENTER). I UNDERSTAND THAT THE CHARGES I AM RESPONSIBLE FOR ARE TO BE PAID AT THE TIME OF SERVICE.

IN THE CASE OF CHILDREN WHOSE RESPONSIBLE PARTY IS SOMEONE OTHER THAN THE CUSTODIAL PARENT, WE ASK THAT PAYMENT BE MADE AT THE TIME OF THE SERVICE BY THE PERSON ACCOMANYING THE CHILD.

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SIGNATURE – PATIENT/REPRESENTATIVE DATE