

\*Patient Demographic Information\*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F

Single  Married  Divorced  Widowed  Separated

Maiden Name \_\_\_\_\_ Mother's First Name \_\_\_\_\_ Father's First Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

\*\*\*\*\*PLEASE GIVE US COMPLETE INFO ON YOUR PRIMARY AND REFERRING DOCTOR'S\*\*\*\*\*

\*Who Referred you to our Practice? \_\_\_\_\_ Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

\*Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Send reports and results to your referring MD? Y  N  Send reports and results to your primary care physician? Y  N

\*Emergency Contact Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

\*Medical Insurance Information\*

Primary Insurance Carrier \_\_\_\_\_ ID # \_\_\_\_\_

Group Name/# \_\_\_\_\_ Relationship to Policyholder:  Self  Spouse  Child  Other

Policyholder Name \_\_\_\_\_ DOB \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_ ID # \_\_\_\_\_

Group Name/# \_\_\_\_\_ Relationship to Policyholder:  Self  Spouse  Child  Other

Policyholder Name \_\_\_\_\_ DOB \_\_\_\_\_

\*Medication/Pharmacy Insurance Information\* (This is usually different than your medical insurer information)

Insurance Carrier Name \_\_\_\_\_ Rx ID # \_\_\_\_\_

Phone # \_\_\_\_\_ If Mail Oder - Mail Order Insurance Carrier \_\_\_\_\_

Pre-Authorization phone # \_\_\_\_\_ Mail Order Insurance Carrier # \_\_\_\_\_

\*Patient Demographic Information\* (Cont'd)

**\*\*PHARMACY INFORMATION\*\* PLEASE ENTER UP TO THREE (3) PHARMACIES\*\***

We will use Pharmacy # 1 at all times unless you notify us otherwise

Pharmacy # 1 \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ Address \_\_\_\_\_

Pharmacy # 2 \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ Address \_\_\_\_\_

Pharmacy # 3 \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ Address \_\_\_\_\_

\*\*If you are Medicare Insured, please read and sign below. Please ensure that if you have secondary insurance, you notify Medicare, and fill out a Coordination of Benefits Form so that your benefits “cross over”, and are paid accordingly. \*\*

**MEDICARE INSURED'S**

I request that payment of authorized health insurance benefits, including Medicare and Medigap, be made either to me, or on behalf of my physician for services furnished to me by this provider. I authorize any holder of medical information about me, to release to the Health Care Financing Administration, or Centers for Medicare, and its agents, any information needed to determine these benefits, or the benefits payable for related services.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

**COMMERCIAL/MANAGED CARE INSURED'S**

I verify the accuracy of the information on this form. I hereby authorize direct payment of surgical/medical benefits to my physician, for services rendered by him/her in person, or under his/her supervision if I have not paid in advance. I understand that I am financially responsible for all services. Additionally, although my doctor will assist in the processing of my claims, I understand that I am responsible for my bill. I hereby authorize my physician to release any medical, or incidental information that may be necessary for either medical care, or in the processing applications for financial benefits.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided with a copy of the Columbia University Health Sciences Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
If personal representative, personal representative's authority to act

\_\_\_\_\_  
Name of Beneficiary \_\_\_\_\_



**ColumbiaDoctors**

*The Physicians and Surgeons  
of Columbia University*

## **Electronic Data Exchange for your Medication History**

At ColumbiaDoctors, we have an electronic health record: **CROWN**.

Our goal is to have **one** medical record for you at ColumbiaDoctors. We **share** information between doctors and advanced care providers within ColumbiaDoctors to improve quality and safety. Quality care in a safe environment is essential to our mission. To assist in our quality and safety initiatives for patient care, ColumbiaDoctors is requesting that you participate in the Electronic Data Exchange for your **Medication History**.

Electronic Data Exchange allows your doctor and/or your advanced care provider at ColumbiaDoctors to take in medication history information from your pharmacies, your insurance company and your Pharmacy Benefit Manager. This will allow your health care providers to see current and past medications that **have been prescribed** to you in the last 180 days. If medications are found during this Electronic Data Exchange, the medications will come into your electronic health record: CROWN. Your doctor and/or advanced care provider will review and verify your list of medications with you during your visit.

This is important because your health care provider should be aware of all medications you are taking and especially if they decide you may need medications to be prescribed during your visit.

At this time, we take in all available medication history for patients with a scheduled appointment at ColumbiaDoctors.

If you do not wish to participate in this electronic exchange of data, you must sign a Refusal to Participate in Electronic Data Exchange. Please ask the staff for this form to sign.