MOREHOUSE HEALTHCARE

STUDENT HEALTH AND WELLNESS CENTER

PATIENT DEMOGRAPHIC PROFILE

DATE: _____

☐ Morehouse School of Medicine ☐ Clark Atlanta University ☐ Morehouse College Graduation Date: _____

Patient Information

Patient Name: _____ D.O. B. _____

Sex: _____ Race: _____Ethnicity _____Preferred Language _____

Local Address: _____Apt. #: _____

City, State: _____ Zip_____

Permanent Address: _____ Apt. #: _____

City, State: _____ Zip_____

Mobile Phone: _____Mobile Phone Carrier: _____Email: _____

Emergency Contact Person _____R/ship to patient_____ Tel: _____

Guarantor's Name (Person responsible for payment): _____R/ship to patient_____

R/ship to patient _____Guarantor's SSN: _____ Telephone #: _____

Address: _____City _____State: _____ ZIP: _____

INSURANCE INFORMATION:

Primary Insurance Co.: (Name/Address) _____Telephone #: _____

Subscribers' Name: _____SSN: _____D.O. B: _____

Address: _____ City: _____ State: _____ ZIP: _____

Subscriber #: _____ Group # or Plan: -_____Effective Date: _____

Secondary Insurance Co.: (Name/Address) _____Telephone #: _____

Subscribers' Name: _____ SSN: _____D.O. B: _____

Address: _____City: _____ State: _____ ZIP: _____

Subscriber #: _____Group # or Plan: -_____Effective Date: _____

AUTHORIZATION: I hereby authorize my insurance, Medicare and /or Medicaid benefits to be paid directly to Morehouse Healthcare, Inc. I understand that I am financially responsible for any balance. I also authorize Morehouse Healthcare, Inc. to release any information requested to process my claim.

Signature: _____ Date: _____

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PHARMACY INFORMATION:

Local Pharmacy Name _____

Location of Pharmacy: _____ Telephone #: _____

Mail Order Pharmacy (if you use one): _____ Telephone #: _____

ADVANCE DIRECTIVES:

Do you have a donor card? _____ Yes _____ No

Do you have a living will? _____Yes _____No (A living will is a written document that allows you as a competent adult to indicate your wishes regarding life prolonging medical treatment, if you become incapacitated).

Do you have a Durable Power of Attorney for Healthcare? _____Yes _____No (A durable Power of Attorney for Healthcare allows you to select an adult to make medical decisions for you).

CONSENT FOR TREATMENT

I grant Morehouse Healthcare permission to provide any medical treatment considered necessary by a clinical provider. I understand that all treatment is voluntary and that I may cease treatment at any time.

_____ _____ _____ _____

Patient Signature Date Parent/Legal Guardian Date