Patient Demographic Form

Patient Name: ____ DOB: ____________________

Address: ____

City: ____ State: ______________ Zip: ____________

Home Phone: ____________________ Cell: _______________________Work: ___________________

Email Address: ____

Preferred Language: ☐English ☐Spanish ☐Other: __________________ Race: __________________

Preferred method of contact:

☐Home Phone ☐Cell ☐Work ☐Email

Appointment Reminders:

☐ I consent to receive reminders via text message

☐ I consent to receive reminders via email

Primary Care Physician Name: ___________________________________ Phone #: ___________________

Pharmacy Name: ____ Phone #: ___________________

Pharmacy Address: ____ Fax# :_____________________

Emergency Contact Name: ________________________Relationship: __________Phone #: _______________

Insurance Information:

Primary Insurance Co.: ____ Phone #: ________________

Member/Policy #: _______________________________________Group #: ________________________

Primary Insured's Name: _______________________________________ DOB: ____________________

Secondary Insurance Co.: ____ Phone #: _______________

Member/Policy #: _______________________________________Group #: ________________________

Primary Insured's Name: _______________________________________ DOB: ____________________

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(Print Name) **Patient or Responsible Party (Signature)** **(Date)**

ACKNOWLEDGEMENT OF HIPAA FORM

I acknowledge I have read the HIPAA Notice of Arthritis & Osteoporosis Center of South Texas (AOCST) and below are listed family members and/or friends with whom it is permissible to share my PHI (Protected Healthcare Information). This authorization will stay in affect unless it is changed by me.

Name of Person(s) Who May Receive My Medical Information

Name	Relationship	Phone Number

In general, the HIPAA privacy act gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

(Print Name) **Patient or Responsible Party (Signature)** **(Date)**

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