Kittery Family Practice
ASSOCIATES
OF YORK HOSPITAL

Kittery Family Practice
35 Walker Street
Kittery, ME 03904
Ph: (207) 439-4430 Fax: (207) 439-0968

PLEASE COMPLETE THE ENTIRE FORM AND PROVIDE YOUR HEALTH INSURANCE CARD

DATE:-_____

Patient's full **legal** name: _____
Last name First name Middle name or initial

Physical home address: _____
Street City State Zip

Mailing address (if different) _____
Street City State Zip

Email address: _____

Date of Birth: _____/_____/_____ SSN_____-_____-_____ Gender:_____

PRIMARY phone: (_____)-_____-_____

Leave message Y N if Yes, Detailed or Brief

SECONDARY phone:(_____)-_____-_____

Leave message Y N if Yes, Detailed or Brief

Work phone: (_____)-_____-_____ Ext._____

Leave message Y N if Yes, Detailed or Brief

See below: The Maine Health Data Organization is requiring all health care professionals to collect data about your background which includes your race, ethnicity and language preference. The purpose of this is to ensure that all patients receive high quality care.

1). Race: (please circle one)

White American Indian/Alaska Native Asian Black/African American
Native Hawaiian /Other Pacific Islander Hispanic Other Refuse to Report

2). Ethnic categories: (please circle one)

Hispanic/Latino Non-Hispanic/Non-Latino Unknown or Refuse to Report

3). Primary language: _____Do you require a translator? **Y N**

If yes, we can help arrange a professionally trained translator to accompany you at your appointments.

Are you hearing impaired? **Y N If yes, we can help arrange a Professional Sign Language Interpreter to accompany you at your appointments.**

Are you a student: **Y N If yes, Full time or Part-time**

Employment status: **Full Part-time Unemployed Retired**

Employer name: _____

Occupation: _____

Employer's address: _____
Street City State Zip

Emergency Contact: _____Relationship:_____

Address: _____
Street or P.O. Box City Zip

Primary phone: (_____)-_____-_____ Secondary phone: (_____)-_____-_____

Work phone: (_____)-_____-_____

Marital Status: Single Married Divorced Widowed Partnered

Domestic Partner's Name: _____ DOB_____/_____/_____

PLEASE PROVIDE YOUR INSURANCE CARD AT EACH VISIT

PRIMARY Insurance name: _____

Policy holder (guarantor) name: _____ **SELF**

Address of policy holder (guarantor):_____

Home phone: (_____)-_____-_____ DOB of policy holder (guarantor): _____/_____/_____

SSN _____-_____-_____ Relationship of guarantor to patient: _____

Employer name of policy holder (guarantor):_____

SECONDARY Insurance name: _____

Address of policy holder (guarantor): _____

Home phone: (_____)-_____-_____ DOB of Policy holder (guarantor): _____/_____/_____

SSN _____-_____-_____ Relationship of guarantor to patient: _____

Employer name of policy holder (guarantor): _____

PLEASE BE SURE YOU HAVE CONTACTED YOUR INSURANCE COMPANY TO CHANGE YOUR PCP IF YOU ARE REQUIRED TO CHOOSE A PRIMARY CARE PROVIDER.

CONSENT TO TREAT

I consent to diagnostic tests, treatments, or planned recurring treatments that the physicians/practitioner (provider) deems necessary. This may also include emergency care if the provider deems necessary.

I understand that I have the right to be informed about the risks, benefits and the alternatives to any care, treatment procedure before I receive it.

I have the right to accept or refuse any medical or surgical care, treatment or procedure.

I authorize release of prescription eligibility and prescription history to be obtained via Electronic Medical Record by Kittery Family Practice of York Hospital.

I authorize release of information needed to continue my care or to determine benefits for the services rendered.

I request that all payment of authorized benefits be made directly to York Hospital and all physicians or other professionals involved in my care.

I am aware that the York Hospital Privacy Notice Booklet has further information about how medical information may be used and disclosed. I have had the opportunity to receive and review this booklet and may request an updated copy at any time.

I acknowledge that I am financially responsible for any copay, coinsurance, deductible, denied or any outstanding balances relating to my health care. I am responsible for providing Kittery Family Practice of York Hospital with the most current insurance information. I further understand that if I do not provide my current insurance, I may be asked to sign an insurance waiver stating that I may be responsible for payment of service, if insurance was not provided at the time of visit.

_____ _____

Signature of patient Print name Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practice followed by Kittery Family practice has been given to me, read, and offered a copy to keep. I've been given an opportunity to ask questions regarding the policy.

Signature: _____ Date: _____

Printed name: _____

Date of Birth: _____

Representative signature: _____

Relationship: _____ Date: _____

Parent or guardian is required to sign for a patient under the age of 18