Patient Information Sheet

St. Luke's MEDICAL GROUP

Referred by _____ Primary Care Physician _____

Patient _____

Address _____

City, State, Zip _____

Home Phone No. _____ Cell Phone No _____ Work Phone No _____

*May we leave a message? **Y** **N*** *May we leave a message? **Y** **N*** *May we leave a message? **Y** **N***

Date of Birth _____ Birth Sex: **M** **F** Marital Status: **Single** **Married** **Widowed** **Divorced** **Separated**

SSN _____ Patient's Employer _____

Employment Status **Full Time** **Part Time** **Retired** **Unemployed** Student Status: **Full Time** **Part Time** **N/A**

Emergency Contact _____ Phone No. _____ Rel. To Patient _____

Person Responsible for Balance _____ Responsible Party's Date of Birth _____

Responsible Party's Address _____ SSN _____

Email Address _____

We are collecting email addresses for those patients that would like to use the Patient Portal for our office to communicate with you via the Web.

Race: (*Please Circle*)

American Indian or Alaska Native
Asian
Native Hawaiian/Pacific Islander
Black or African America
White
Hispanic
Other Race
Unreported/Refused to Report

Ethnicity: Hispanic Non-Hispanic Refused to Report **Preferred Language:** _____

Pharmacy: ❑ St. Luke's Retail Pharmacy 314-205-6023 ❑ St. Luke's Retail Pharmacy: Winghaven Location 636-695-2555

❑ Local Pharmacy Name_____ Local Pharmacy Telephone No._____

❑ Mail Order Pharmacy Name_____ Mail Order Pharmacy Telephone No._____

INSURANCE INFORMATION (COPIES OF INSURANCE CARDS REQUIRED)

Primary Insurance _____ Effective Date _____

Name of Insured/Subscriber _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's I.D. No. _____ Group No. _____

Secondary Insurance _____ Effective Date _____

Name of Insured/Subscriber _____ Relationship to Patient

Insured's Date of Birth _____ Insured's I.D. No. _____ Group No. _____

ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS/RELEASE OF MEDICAL INFORMATION: I hereby authorize this St. Luke's Medical Group physician to administer / perform any treatment deemed necessary and authorize release of information needed to secure payment. I authorize that all benefits by my insurance company be paid directly to St. Luke's Medical Group, and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. In addition, I hereby authorize the release of all applicable medical information including & without limitation copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and such other health care practitioners or organizations who/which will be providing subsequent monitoring of care or treatment in connection with care provided by the St. Luke's Medical Group

Signature of Responsible Party _____ Date _____

Acknowledgement of Privacy Practice and Patient Rights

1. Patient Rights: A copy of my Patient Rights has been made available to me.
2. Notice of Privacy Practice: A copy of St. Luke's Hospital Notice of Privacy Practice has been made available to me.

_____ _____ _____

Signature of Patient (or Legal Guardian/Representative) **Date** **Relationship to Patient**

❑ Patient unwilling or unable to sign acknowledgement **Reason**: _____

Revised 12.6.2022
JLM