DAKOTA PREMIER
MEDICAL CLINIC

Dakota Premier Medical Clinic New Patient Form

Demographic Information:

Date: ___________

Patient Legal Name: ____ **Date of Birth**: ________________
Last First MI

Patient Soc. Sec. #: ____________________ **Sex:** __Male __Female __ Decline

Address: ____
Street or BO Box City State Zip

Phone No. (_____) ________-__________ Email: ____

Marital Status: __Married __ Single __Divorced __Separated __Widowed __Other ____________

Language: __English __Spanish __Other ____________

Race: __White __American Indian or Alaskan Native __Asian __Hispanic __Black or African American
__Hawaiian or Pacific Islander __Other __Decline

Ethnicity: __Hispanic or Latino __Not Hispanic or Latino __Decline

Emergency Contact Information:

Emergency Contact Name: ____

Relationship to Patient: ______________________________________ **Phone No**. (_______) ________-__________

Employment:

__Employed __Unemployed __Retired __Disabled

Employed By: ____ **Work phone No.** (______) _________-__________

Additional Information:

Preferred Pharmacy: ____

Pharmacy Address: ____

I authorize my provider to review my medication fill history.
__ Yes __No

How did you hear about us?
__ Social Media __ Website __ Referral __ Radio __ Other __________

I authorize Telehealth visits with my provider.
__ Yes __No

2006 Mt Rushmore Rd Suite 2 Rapid City, SD 57701

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Insurance Information:

Insurance Name: ______________________________________ **Policy Holder Name:** ____

Address: ____
Street or BO Box City State Zip

Policy Holder Date of Birth: _______________ **Relationship to Patient:** ______________________ **Group Number:** _____________

Policy Number: ________________________ **Payer ID Number**:___________________________ **Effective Date:**______________

Secondary Insurance Information:

Insurance Name: ______________________________________ **Policy Holder Name:** ____

Address: ____
Street or BO Box City State Zip

Policy Holder Date of Birth: ______________ **Relationship to Patient:** ________________________**Group Number:** _______________

Policy Number: ________________________ **Payer ID Number**:____________________________ **Effective Date:** _______________

Responsible Party

Name: ____ **Date of Birth:** _______________
Last First MI

Address: ____
Street or BO Box City State Zip

Relationship to Patient: __________________________ **Phone No.** (_____)_____-__________

Assignment of Benefit:
I hereby assign all medical benefits to which I am entitled to Dakota Premier Medical Clinic. I further authorize the assignee to obtain my plan provisions under ERISA and to act as an authorized representative on my behalf on insurance claims. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical record copies, necessary to secure payment and to complete disability forms presented to me. In response to any reasonable request for cooperation, I agree to cooperate with Dakota Premier Medical Clinic in any attempts by Dakota Premier Medical Clinic to pursue such claim, chosen in action or right against my insurers and/or employee health care plan. Certain physicians (e.g. pathologists and radiologists) may interpret your test results. These physicians may not be employees or agents of Dakota Premier Medical Clinic and you may, therefore, receive a separate bill from these physicians for their services. A $40 plus tax service charge will be assessed against all non-sufficient funds/closed account checks. I have read and fully understand this agreement.

Patient's Name: ____ **Date:** ______________________________

____

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HIPAA Privacy Authorization to Individuals

As required by the Health Insurance Portability and Accountability Act of 1996, Dakota Premier Medical Clinic may not use or disclose your health information to anyone without your authorization, except as provided in our Notice of Privacy Practice. Your signature on this form indicates that you are giving permission for the uses and disclosure described herein. You may revoke this authorization in writing at any time by signing and dating a revocation form and returning it to this office.

I, ________________________________, authorize and request the following persons to receive these disclosures of my health information and elect not to provide a statement of purpose for the use of disclosure for the following persons:

Name: ____**Relationship:** ____________________ **Phone No.** (____) ______-____________

___All Health Information ___Progress Notes ___Lab Reports ___Image Reports___ Medications

___Other: ________________________________

Name: ____**Relationship:** ____________________ **Phone No.** (____) ______-____________

___All Health Information ___Progress Notes ___Lab Reports ___Image Reports___ Medications

___Other: ________________________________

Name: ____**Relationship:** ____________________ **Phone No.** (____) ______-____________

___All Health Information ___Progress Notes ___Lab Reports ___Image Reports___ Medications

___Other: ________________________________

I understand that I am authorizing Dakota Premier Medical Clinic to make the above disclosure of my health information.
I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer be protected. I understand that this authorization will automatically expire one year from the date this form is signed, but that I may revoke this authorization at any time by signing the revocation section of the Use and Disclosure form and returning it to Dakota Premier Medical Clinic. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

I have received a copy of Dakota Premier Medical Clinic's Privacy Notice.

Patient's Name:____ **Date:**____

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Consent for Medical Treatment of a Minor

Children under the age of 14 must be accompanied by an adult for any appointment. As the Parent/Guardian of _______________ a minor, I am authorizing the following:

____I authorize to be seen at Dakota Premier Medical Clinic without a parent or guardian present.

___I authorize a minor, to be seen and/or treated at Dakota Premier Medical Clinic facility when accompanied only by one of the following adults listed:

Name:____**Relationship:** _________________________________**Phone No. (_____)______-________**

Name:____**Relationship:** _________________________________**Phone No. (_____)______-________**

Name:____**Relationship:** _________________________________**Phone No. (_____)______-________**

I further understand this authorizes Dakota Premier Medical Clinic to provide medical and/or billing information to various laboratories, radiology, or other medical facilities for a test that may become necessary for treatment. I accept responsibility for all physician charges and laboratory fees. This authorization will remain in effect until revoked by me or the minor becomes 18.

Parent/Guardian Name: ____

Parent/Guardian Signature: ____ **Date:** _____________