St. Luke's Medical Group — Patient Data Sheet

Referred by _____ Primary Care Physician _____

Patient _____

Street Address _____ City, State, Zip _____

Home Phone No. _____ *May we leave a message? Y N*

Cell Phone No _____ *May we leave a message? Y N*

Work Phone No _____ *May we leave a message? Y N*

Date of 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 Patient Portal for our office to communicate with you via the Web. For more information, please ask at Check In/Out. This feature will be available in the near future.

Race: (*Please Circle*)

American Indian or Alaska Native
Asian
Native Hawaiian
Black or African America
White
Hispanic
Other Race
Other Pacific Islander
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

☐ Other Local Pharmacy Name_____ Other 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:_____

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e-Prescribing Consent

ePrescibing is defined as a Physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that that ability to electronically send prescriptions is an important element in improving the quality of Patient care. ePrescribing greatly reduces medication errors and enhances Patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe Program. These include:

Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
Medication history transactions – Provides the physician with information about medications the Patient is already taking to minimize the number of adverse drug events.
Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the Patient's prescription has been picked up, not picked, or partially filled.

By signing this consent form you are agreeing that (Practice Name) can request and use your prescription medication history from other healthcare Providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to (Practice Name) to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name: _____ Patient DOB: _____

Signature of Patient or Guardian: _____ Date: _____

Relationship to Patient: _____

E-Messaging Services

Please note: our Practice will now be sending notifications to our Patient's using an electronic reminder system through our Electronic Health Records. Please select the types of alerts you would like to receive and indicate how you would like to receive these alerts. (Via, Phone Call/Text Message)

Type of Patient Notification	Method of Communication	Preferred Time to Call	Preferred Language
Patient Appointments Lab Results Health Maintenance (regularly required tests and procedures) RX Confirmation General Notification	❑Home Phone ❑Work Phone ❑Cell Phone (Phone Call) ❑Cell Phone (Text MSG)	❑AM (6am-12pm) ❑Afternoon (12-4pm) ❑PM (4-9pm)	❑ English ❑ Spanish

Please list all individuals that we may communicate with regarding your medical information

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

❑ Please check if ok to leave a message on answering machine