DR. KAMILIA SMITH

CHARLESTON

HOUSE

WOMEN'S HEALTH & WELLNESS

## Demographic Information Form

NAME ____________________________________________ DOB ______________________ SS# ______________________

ADDRESS ______________________________________________________________________ APT# ____________________

CITY _____________________________________STATE _____________________ ZIP ________________________________

HOME # ______________________________ MOBILE # _________________________ CONSENT TO TEXT ( ) YES ( ) NO

EMPLOYER ________________________________OCCUPATION ______________________ WORK # ____________________

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED

EMAIL _______________________________________________REFERRED BY ______________________________________

SPOUSE INFO (IF MARRIED) OR PARENT INFO (IF MINOR)

NAME ____________________________________________ DOB ______________________ SS# ______________________

CONTACT# _____________________________________________________

EMERGENCY CONTACT

NAME ______________________________________RELATIONSHIP ______________________ CONTACT#_______________

INSURANCE INFORMATION

PRIMARY INSURANCE ____________________________________ POLICY HOLDER ( ) SELF ( ) SPOUSE ( ) PARENT ( ) OTHER

POLICY HOLDER NAME _____________________________ POLICY HOLDER DOB _______________________________

INSURANCE # __________________________________________ POLICY HOLDER SS# ________________________________

ID# ____________________________ GROUP# _______________ POLICY HOLDER EMPOLYER __________________________

SECONDARY INSURANCE _________________________________ POLICY HOLDER ( ) SELF ( ) SPOUSE ( ) PARENT ( ) OTHER

POLICY HOLDER NAME ___________________________________ POLICY HOLDER DOB _______________________________

INSURANCE # __________________________________________ POLICY HOLDER SS# ________________________________

ID# ____________________________ GROUP# _______________ POLICY HOLDER EMPLOYER __________________________

AUTHORIZATION: I authorize the release of any medical or other information necessary (patient sharing records) to process claims filed by Charleston House – Dr Kamilia T. Smith.

PATIENT/GUARDIAN SIGNATURE ______________________________________________________DATE ________________________

DR. KAMILIA SMITH

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HIPAA Authorization for Release of Patient Health Information

HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means. The information will remain in effect until revoked in writing.

I wish to be contacted in the following manner (check all that apply):

- ☐ Cell Phone:
  - ☐ Ok to leave message with detailed message
  - ☐ Leave name and doctor with call back number only
  - ☐ Ok to text message with detailed message
  - ☐ Do not text
- ☐ Home Phone:
  - ☐ Ok to leave message with detailed message
  - ☐ Leave name and doctor with call back number only
- ☐ Work Phone:
  - ☐ Ok to leave message with detailed message
  - ☐ Leave name and doctor with call back number only
- ☐ Other: ____________________________________________

I consent and authorize the release of medical information, including diagnosis, treatment and results, to the following:

- ☐ Only Myself
- ☐ My spouse/partner: ______________________________________
- ☐ My children: ______________________________________
- ☐ My parents: ______________________________________
- ☐ Other: ______________________________________

_______________________________________________________________

Patient Signature Date

_______________________________________________________________

Print Name Date of Birth

DR. KAMILIA SMITH

CHARLESTON

HOUSE

WOMEN'S HEALTH & WELLNESS

Request For Private Health Information

Patient Information (Please Print)

| First Name: | MI: | Last Name: | | |
|---|---|---|---|---|
| Date of Birth: | | Phone: | | |
| Street Address: | | City: | State: | Zip: |

What records are being requested?

Name of Physician: ____________________________________________

Date of Service(s): _____/_____/_____ through _____/_____/_____

☐ H & P ☐ Office Visit Notes

☐ Lab Results ☐ Cardiac Studies

☐ Imaging Studies ☐ ALL Records

☐ Other (Specify): ___________________________________________

Please send records to:

- Mail to: Charleston House – Dr. Kamilia Smith
  3611 Swiss Ave., Ste 201, Dallas, TX 75204
- Fax to: 214-247-1160

Please print your name and sign below:

Name of Patient/Representative: _______________________________________

Relationship to Patient: _______________________________________

Signature: _______________________________________

Date: _______________________________________