Burke Primary Care Patient ID:_____

Patient Demographic Form

Last Name:			SSN#:			
First Name:		Middle Initial:	DOB:		Sex	
Home Address1:			Age:			
Apt/Suite #:			Home Tel#:			
City, State, Zip:			Work Tel#:			
Email:			Cell Tel#:			
Race:		Ethnicity:		Language:		
Marital Status:		Assigned Provider:				
Mother's Maiden Name:						
HOW DO YOU PREFER YOUR APPOINTMENT REMINDER (please check boxes below)						
Preferred Phone:	Home ☐ Work ☐ Cell ☐		Communicate by:	Voice ☐ Email ☐ Text ☐		
EMERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?)						
Name:		Tel#		Relationship to patient:		
PRIMARY INSURANCE						
Plan/Policy Name:			Group #:			
Plan Tel#:			Subscriber DOB:			
Subscriber Name:			Subscriber ID:			
Relationship to Patient: (check box) ☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other						
SECONDARY INSURANCE						
Plan/Policy Name:			Group #:			
Plan Tel#:			Subscriber DOB:			
Subscriber Name:			Subscriber ID:			
Relationship to Patient: (check box) ☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other						
AUTHORIZATION FOR RELEASE OF INFORMATION						
Burke Primary Care is authorized to release protected health information about the above-named patient to: ☐ NONE, only myself ☐ Name/Phone number _____						

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

I acknowledge that I have received a copy of the Notice of Privacy Practices for Burke Primary Care.

I authorize the release of medical records and any other information necessary to process medical claims. I authorize payment of insurance claims to be made to my medical provider. I assume responsibility for charges incurred if accurate insurance information is not presented at the time of service.

I give Burke Primary Care consent to retrieve my immunization records from NC state registry. Burke Primary Care providers may use HIPAA-complaint AI tools to assist with documentation of patient visits. These tools summarize the patient visit with the Provider reviewing and editing the encounter for accuracy.

Patient or authorized person's signature: _____ **Date:** _____

If not signed by patient, please complete the following:
Guardian/Authorized Representative Name: _____ Relationship to patient: _____