



Nevada Health Centers, Inc.
PATIENT DEMOGRAPHICS
 (All information is strictly confidential)

Last Name	First	Middle Initial	Birth Date: / /	
Street Address	Apt #	City	State	Zip
Mailing Address / P.O. Box	Apt #	City	State	Zip

Student?: No Full Time Part Time Marital Status: Single Married Divorced Domestic Partner Veteran: Yes No

Cell Phone Number ()	Daytime Phone Number ()	Alternate Phone Number ()	Primary Language: _____ Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic
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E-mail Address: _____

Birth Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male / Female-to-Male <input type="checkbox"/> Transgender Female / Male-to-Female <input type="checkbox"/> Other <input type="checkbox"/> Chose not to disclose	Sexual Orientation: <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Chose not to disclose	Preferred Pronoun(s): <input type="checkbox"/> He, Him, His <input type="checkbox"/> She, Her, Hers <input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Ze, Hir <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other
Current Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undifferentiated			

Which of the following groups do you feel you belong to? American Indian/Alaska Native Black/African American White Asian
 Pacific Islander Native Hawaiian Refused to report

Emergency Contact (REQUIRED)	Phone ()
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Responsible Party (Parent, or legal guardian information. If patient is 18 years or older please print the patient's information.)

Last Name	First	Middle Initial		
Street Address	Apt #	City	State	Zip
Mailing Address / P.O. Box	Apt #	City	State	Zip

Home Phone ()	Annual Income: (We need this information for statistical purposes) <input type="checkbox"/> \$24,000 or less <input type="checkbox"/> \$25,000 to \$49,999 <input type="checkbox"/> \$50,000 to \$74,999 <input type="checkbox"/> \$75,000 to \$99,999 <input type="checkbox"/> \$100,000 or more <input type="checkbox"/> Refused to report (Initials _____)
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Employer's Name	Employer's Address (street address, city and state)	Phone ()
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Medical Insurance

1 - Primary Insurance Company	ID #	Group #	Address
Name of Insured	DOB	Insured's Employer	Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
2 - Secondary Insurance Company	ID #	Group #	Address
Name of Insured	DOB	Insured's Employer	Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other

I hereby voluntarily consent to outpatient care with Nevada Health Centers, Inc., encompassing routine, minor surgical and diagnostic procedures. I furthermore consent to the performance of examination and procedures by the medical staff and their assistants, including physician assistants and advanced practice nurses. I understand that physician assistants and advanced practice nurses are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician. I agree to the release of medical records and information including those related to medical treatment, surgical procedures, laboratory testing, psychological services and consultations to any person or entity responsible for payment to NVHC.

Signature of Patient, Parent or Legal Guardian	Date
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Nevada Health Centers, Inc.
FINANCIAL AGREEMENT

I authorize the direct payment of any benefits due to me for the services provided by Nevada Health Centers, Inc. be paid directly to Nevada Health Centers, Inc. by my insurance company.

I realize that although Nevada Health Centers, Inc. may be billing my insurance company on my behalf, I am ultimately responsible for the balance on my account.

Medicare Patients: I understand that Nevada Health Centers, Inc. accepts assignment with Medicare, however, I am responsible for a 20% copay at the time of service. Nevada Health Centers, Inc. will bill my supplemental insurance, as long as I provide all information necessary to do so. I understand that Medicare only pays for services it considers to be medically necessary and that the case may arise that I request services Medicare will not pay for, I would be responsible for payment in full.

Medicaid Recipients: Federal and State statutes require utilization of all other sources before billing Medicaid for medical services. Other sources include private or employer-provided health and accident insurance coverage. I certify under penalty of fraud that I do not have private or employer provided health and accident insurance, as a primary payer, for my dependents or myself. I understand that Medicaid only pays for services that are to treat a medical condition or illness.

Private Insurance Patients: I understand that I am responsible for knowing what benefits are covered by my insurance policy. I understand that Nevada Health Centers, Inc. will verify benefits, but does not guarantee any service will be a covered benefit. I understand that if my insurance does not cover any services received, I will be responsible for payment. I understand that my copay is due and payable at the time of service.

Self Pay Patients: I understand that it is the policy of Nevada Health Centers, Inc. to collect payment for services at the time of service.

Third-Party Collection Agency: If you have not responded to our attempts to reach you about any unpaid balances, we may opt to send your account to a collection agency.

Patient Signature / Parent (For Minor Patient)

Date

Witness

Date