NOAH
Neighborhood Outreach Access to Health

Demographic Form MRN:_____

PARENT / GUARDIAN INFORMATION		
Mother's Information (Last, First, Middle)	**Mother's Date of Birth**	
Father's Information (Last, First, Middle)	**Father's Date of Birth**	
Guardian's Information (Last, First, Middle)	**Guardian's Date of Birth**	
Home Address (Local)		
City	**State**	**Zip Code**
Primary Phone #	**Secondary Phone #**	
Email Address		

PATIENT INFORMATION		
(1) Last Name, First, Middle	**Gender**	**Date of Birth**
(2) Last Name, First, Middle	**Gender**	**Date of Birth**
(3) Last Name, First, Middle	**Gender**	**Date of Birth**
(4) Last Name, First, Middle	**Gender**	**Date of Birth**
(5) Last Name, First, Middle	**Gender**	**Date of Birth**
(6) Last Name, First, Middle	**Gender**	**Date of Birth**
(7) Last Name, First, Middle	**Gender**	**Date of Birth**
(8) Last Name, First, Middle	**Gender**	**Date of Birth**

INSURANCE INFORMATION			
☐ AHCCCS	☐ NO INSURANCE	☐ COMMERCIAL/PRIVATE	☐ Discount Program: Sliding Fee Scale
Plan name: If applicable:		ID #:	

Patient name: _____ Patient DOB: _____

Patient Bill of Rights and Responsibilities

Except where medically contraindicated, these rights apply to all adults, neonates, children and adolescents treated at Neighborhood Outreach Access to Health (NOAH) outpatient/physician office facilities and their parents and/or guardians.

Signature of Patient or Responsible Party if a Minor

X_____

Authorization to Release Information and Assignment of Medical Benefits

I HEREBY AUTHORIZE NOAH, to treat the named patient. I AUTHORIZE RELEASE OF MEDICAL INFORMATION necessary to process insurance claims concerning my illness and treatment. Photocopies are valid as original. I AUTHORIZE PAYMENT of medical benefits for medical care rendered to myself or my dependents. I understand I am financially responsible for any amounts not covered by my health insurance.

Signature of Patient or Responsible Party if a Minor

X_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOAH is committed to protecting the confidentiality of its patients' medical information, and is required by law to do so. This Notice describes how we may use your medical information within the HonorHealth system and how we may disclose it to others outside of NOAH. This Notice also describes your rights concerning your own medical information. Please review it carefully and let us know if you have questions.

Signature of Patient or Responsible Party if a Minor

X_____

MRN:_____ MRN:_____ MRN:_____

MRN:_____ MRN:_____ MRN:_____