Patient Registration Form

****PLEASE COMPLETE BOTH SIDES OF THIS FORM****

PATIENT INFORMATION

Patient's Name (Last)_____ (First) _____(MI)_____

Address _____ City_____ Zip_____

Home Phone_____Cell Phone _____ Work _____ext._____

E-Mail Address_____ Primary Care Provider _____

Date of Birth: _____/_____/_____ Sex: ☐ Female ☐ Male SS# _____-_____-_____

Employer _____Occupation _____

- **Preferred Pharmacy** Name/Location_____

Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Black or African American ☐White ☐Declined

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined ☐Other _____

Language: ☐ English ☐Spanish ☐ Indian ☐Japanese ☐Chinese ☐Other _____

Marital Status: ☐Married (Spouse's Name)_____ ☐Single ☐Divorced ☐Widowed ☐Legally Separated ☐Domestic Partner (Partner's Name)_____

Emergency Contact/Relation _____Phone_____

RESPONSIBLE PARTY INFORMATION (MINORS)

Responsible Party Name (Last)_____ (First)_____ (MI)_____

Address Line 1 _____City_____State_____ZIP_____

SS Number ____-____-_____ DOB ____/_____/_____ Phone _____ E-Mail_____

Relationship to Patient _____ Employer _____

INSURANCE INFORMATION *CARD IS NOT NEEDED TO COMPLETE THIS SECTION

Primary Insurance Company Name _____ Subscriber Name_____

Subscriber DOB _____/_____/____ Subscriber SS#_____-_____-_____ Relationship to Patient _____

Secondary Insurance Company Name _____Subscriber Name_____

Subscriber DOB___/____/_____ Subscriber SS#_____-_____-_____ Relationship to Patient_____

I agree that the information supplied on the form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____***Date***_____

❖ **FLIP PAGE OVER FOR AUTHORIZATION PAGE**

AUTHORIZATION

PRIVACY: Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing the consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease

The Practice may condition receipt of treatment upon the execution of this Consent.

Do we have permission to:

Leave a message on your answering machine at home? ☐ YES ☐ NO

Leave a message at your place of employment? ☐ YES ☐ NO

Discuss your medical condition with any member of your household? ☐ YES ☐ NO

If yes, whom: _____ Relationship _____

Patient (or Responsible Party) Signature _____ **Date**_____

MEDICARE PATIENTS: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me.

Medicare Patient Signature _____ **Date**_____

FINANCIAL: I understand that my insurance will be billed as a courtesy; however I acknowledge that I am responsible for any deductible, copay, or coinsurance. I also understand that it is my responsibility to obtain referrals from my primary care physician when required. If I have no insurance, I agree to pay all charges in full at the time of service.

Patient (or Responsible Party) Signature _____ **Date**_____