PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____

SOCIAL SECURITY #:_____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE:_____ ZIP: _____

LANGUAGE: _____ LANGUAGE COUNTRY:_____

MARITAL STATUS: ☐SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT:_____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _____(what medical facility?)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE _____ ZIP:_____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP:_____

BUSINESS PHONE # : _____

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EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____ BUSINESS NAME: _____

BUSINESS PHONE: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY _____

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by _____ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to _____ releasing information to me in the following manners:

	PLEASE INITIAL
VIA MAIL	
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
☐ OK TO FAX TO: _____	_____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____