PATIENT REGISTRATION FORM

NAME: ____ JR / SR

LAST FIRST MIDDLE

______________________ MARITAL STATUS: S M D

ADDRESS SINGLE MARRIED DIVORCED

______________________ SS#: ______________________

CITY STATE

______________ MALE FEMALE DATE OF BIRTH: ______________________

ZIP CODE SEX (PLEASE CIRCLE) AGE

EMPLOYER: ______________________ HOME/ DAY PHONE: ______________________

______________________ WORK PHONE: ______________________

ADDRESS CELL PHONE: ______________________

FOR PRACTICE UPDATES AND INFORMATION

WERE YOU REFERRED BY A PHYSICIAN? IF YES, PLEASE GIVE NAME:

ELECTRONIC MEDICAL CHART

EMAIL ______________ ________________ (THIS IS IMPORTANT FOR YOUR PATIEINT PORTAL ACCESS)

Do you want access to your Electronic Chart through our patient portal? Yes_______ No________

PHARMACY INFORMATION

NAME OF PHARMACY: ______________________ PHONE # ______________________

ADDRESS: ____

May we leave personal medical and/or billing information on your answering machine? yes no

In the event of an emergency, who may we contact to inform them of your condition? yes no

Name: ______________________ Relationship: ______________________ Phone #:________________

May we discuss your medical information with family members? yes no if yes,

Name: ______________________ Relationship: ______________________ Phone #: ________________

Our physicians are participating providers with Traditional Medicare, Anthem, Humana, Medical Mutual or Aetna. For insurances not listed, we will copy your insurance card and submit the claim as a courtesy, but you will be responsible at the time of service for payment of services rendered. Medicare HMO patients will be responsible for all charges for services rendered. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient and he/she is financially responsible for these charges. We do not accept Medicaid. Your signature below acknowledges your understanding of these policies. In addition, the Health Care Insurance Portability and Accountability Act (HIPAA) requires this practice to publish a Notice of Privacy Practices which describes how your health information may be used and disclosed for the normal healthcare operations of this practice (including the release of information for billing and collection purposes as well as to another healthcare provider for purposes related to your treatment). Your signature below signifies that a copy of this Notice has been made available to you.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN______________________________ Date_________________