# Patient Registration Form

Name:* _____ single married divorced widowed
**Put patient name exactly as it appears on the Insurance Card** **please circle**

Address: _____

MALE FEMALE
City/State/Zip: _____ please circle

**FOR PRACTICE UPDATES AND INFORMATION**

Social Security #: _____ Date of Birth: _____ Age: _____ years

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Employer: _____

Insurance Policy Holder: _____ Date of Birth_____

Prescription Drug Coverage Carrier: _____ID#_____

**……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: _____

Answer questions below by placing a check in the appropriate column:

| **Yes** | **No** | |
|---|---|---|
| ☐ | ☐ | Were you referred here by another physician?<br>If yes, please give the name of the Doctor: _____ |
| ☐ | ☐ | Who is your primary care doctor? _____ |
| ☐ | ☐ | ***May we leave personal medical and/or billing information on your answering machine?*** |
| ☐ | ☐ | ***May we discuss your medical information with family members?***<br>If yes, please provide their name and phone number: _____<br>_____ |

Please read and sign the following statement:

Our providers participate with Traditional Medicare, Aetna, Anthem, Humana Medicare and most Medical Mutual plans. For insurances not listed, you will be responsible for payment of services rendered at the time of service. We do not participate with Medicaid plans. This office is required to keep your signature on file authorizing us to file insurance claims for you and to release information to that payor if they request it for proper consideration of a claim.

I authorize any holder of medical or other information about me to release to my insurance carrier any information required for this or any medically-related claim. I permit a scanned copy of this authorization to be used in place of the original.

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 related to your treatment). Your signature below signifies that a copy of this Notice has been made available to you.

Signature Date