## PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

### PATIENT INFORMATION

| Patient Name | Today's Date | Date of Birth | Sex | Age |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| Parent (if Patient is a Minor) | Marital Status |
| Patient's Social Security Number | Driver License No. |
| Home Address | Mailing Address if Different |
| City State ZIP | City State ZIP |
| Home Telephone | Work Telephone |
| Cell Phone | E-mail Address |
| Occupation | Employer's Name |
| Employer's Address | City State ZIP |
| Spouse Name | Employer |
| Name of Primary Care Physician | WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? |

### NOTIFY IN CASE OF EMERGENCY

| | |
|---|---|
| Name | Relationship |
| Address | Home Telephone |
| City State ZIP | Work Telephone |

### FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

| | |
|---|---|
| Insurance Company | Subscriber's Date of Birth |
| Subscriber's Name | Insurance ID No. Group No. |
| Secondary Insurance | Subscriber's Date of Birth |
| Subscriber's Name | Insurance ID No. Group No. |

### ASSIGNMENT OF INSURANCE BENEFITS

**Lifetime Authorization**

**Medicare:** I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other pertinent information about me to release to the Social Security Administration or its intermediaries or carriers any information or documentation needed for this or a related Medicare claim. I authorize the physician organization to submit a claim to Medicare on my behalf. I request the payment for services provided be made directly to the physician organization.

**I request this authorization also apply to all insurance plans.**

Patient Name (Please Print) _____ Date _____

Signature _____ Date _____

If signed by other than beneficiary, state the reason the patient was unable to sign: _____

_____

## PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communications of PHI be made by alternative means.

I wish to be contacted in the following manner (check all that apply):

**Home Telephone:** _____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave message with call-back number only.
- ☐ O.K. to speak to: _____

**Written Communication:**

- ☐ O.K. to mail to my home address and/or email address.
- ☐ O.K. to mail to my work/office address.
- ☐ O.K. to address: _____ (name)

**Work Telephone:** _____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave message with call-back number only.
- ☐ O.K. to speak to: _____

**Cell Phone/Other:** _____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave message with call-back number only.
- ☐ O.K. to speak to: _____

Please complete the following to give your authorization for our office to speak with anyone other than yourself regarding your medical care. If left blank I understand that no one other than me (patient) will have the authority to speak with our offices regarding my medical care.

Print Name _____ Relationship _____

Print Name _____ Relationship _____

Please initial:

_____ I have received the "Notice of Privacy Practices" for this office.

By signing below, I acknowledge that I have read and agreed to all the above information:

Patient's Name _____ Date _____

Patient Signature _____