**PATIENT REGISTRATION FORM**

**PATIENT INFORMATION:**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Maiden Name/Also Known As (AKA): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SSN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:** M or F **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:** M S D W

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Phone #:** Cell/Home/Work

**Race:** **\_\_\_**American Indian or Alaska Native **\_\_\_**Asian **\_\_\_**Black or African American

**\_\_\_** Native Hawaiian/Pacific Islander **\_\_\_**White Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ethnicity: \_\_\_** Hispanic/Latino **\_\_\_**Not Hispanic/Latino **Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a Primary Care or Family Physician (PCP)?** Yes/No **PCP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PCP City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How were you referred to our office today?**

**\_\_\_** My Physician/Doctor’s Office (Drs Name) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (City, State) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_** Relative, Friend, or Neighbor  **\_\_\_** Mailing **\_\_\_** Walk In/Drive By **\_\_\_** Insurance Network

**\_\_\_** Hospital/ER (Which?) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_** Urgent Aid (Which?) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT TO TREATMENT AND RELEASE OF INFORMATION:**

Unless otherwise directed below, if I am unavailable, the Physician may communicate normal test results via home telephone, voicemail or answering machine to the home phone numbers on this form, as long as the nature of the call is not disclosed.

* In addition, my normal rest results may be left on the following answering machine/voicemail: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* In addition, my normal test result may be communicated to: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Relationship:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* No, I want my test results only communicated personally to me. **Initials:** **\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize examination and medical treatment, verification of benefits and the release of information (including the diagnosis and medical records) to other physicians involved in my care, to my insurance company to facilitate billing and reimbursement, and for quality assurance purposes. I acknowledge that I have been offered and received or declined to receive a copy of the HIPAA Notice of Privacy Practices. I authorize benefits to be paid directly to the Physician and I understand that I am responsible for any unpaid balance under the terms of my insurance policy.

**Print Patient/Legal Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**