PATIENT REGISTRATION FORM

Date: ____________________________ Chart No: _______________

Name, First: _____________________________________ Middle: _____________________________________

, Last: _____________________________________ Maiden Name: _______________________________

Street Address: ____ Soc. Sec. #: _____________________

City: _____________________________________ State: __________________ Zip: ______________

Home Phone: _____________________ Work Phone: ____________________ Cell Phone: ___________________

Email Address: ____

Date of Birth: ___________________ Place of Birth: _______________________ Marital Status: ________________

Occupation: ____ Length of Employment: _________________

Employer:
____

Spouse / Parent: ____ Soc. Sec. #: ___________________________

Date of Birth: ____________________ Occupation: ____

Work Phone: _____________________ Employer: ____

Emergency Notification (other than spouse): ____

Relationship to Patient: ________________ Home Phone: __________________ Work Phone: ___________________

Referred to Office By:
____
.

PLEASE READ AND SIGN BOTH LINES BELOW;

AUTHORIZATION TO PAY PHYSICIAN; I hereby authorize payments directly to the physician for Medical Benefits, if any, otherwise payable to me for services as described, realizing that I am responsible to pay for all non-covered services.

____ __________________________________

Patient's Signature (Parent or Guardian if patient is a minor) Date

CONSENT FOR PRIVACY POLICY; Our office is bound by federal law to use and disclose your protected health information only for the purposes of treatment, payment, healthcare operations, and special situations required by law. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. Our Notice of Privacy Practices is posted in the office and a copy is available upon request. You have a legal right to review our Notice of Privacy Practices before you sign this consent.

Our Notice of Privacy Practices is subject to change. If we change our notice you may obtain a copy of the revised notice by contacting our office.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, and health care operations, but we are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

____ __________________________________

Patient's Signature (Parent or Guardian if patient is a minor) Date