PATIENT REGISTRATION

PATIENT'S NAME | PATIENT'S DATE OF BIRTH (MM / DD / YYYY) / / | PATIENT'S SOCIAL SECURITY #

EMAIL | SEX ☐ M ALE ☐ FEMALE | PATIENT'S STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER ☐ FULL-TIME STUDENT ☐ PART TIME STUDENT

PATIENT'S HOME PHONE # | PATIENT'S WORK PHONE # | PATIENT'S CELL PHONE #

PATIENT'S ADDRESS (#, street) | CITY | STATE | ZIP CODE

PATIENT'S EMPLOYER | EMPLOYER PHONE #

EMPLOYER ADDRESS (#, street) | CITY | STATE | ZIP CODE

IS TODAY'S EXAM RELATED TO THE FOLLOWING: If **YES** either, please provide date of injury/accident

WORK INJURY? ☐ YES ☐ NO AUTO ACCIDENT? ☐ YES ☐ NO / /

INSURANCE NAME | INSURANCE PHONE #

INSURANCE ID # | INSURANCE GROUP #

NAME OF PRIMARY INSURED | PRIMARY INSURED'S DATE OF BIRTH / / | RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

(SECONDARY INSURANCE) IS THERE ANOTHER HELATH PLAN BENEFIT? ☐ YES ☐ NO

INSURANCE NAME | INSURANCE PHONE #

INSURANCE ID # | INSURANCE GROUP #

I, HEREBY,AUTHORIZE THE FOLLOWING PERSON(S) ACCESS TO MY MEDICAL RECORDS/FINANCES:

______________ ______________ ______________

Acknowledgment of PRIVACY PRACTICES, ASSIGNMENT AND CONSENT

I have reviewed the NOTICE of PRIVACY PRACTICES and authorize the release of any medical or other information necessary to process this claim. I also request payment of insurance or governmental benefits directly to my provider. The Notice of Privacy Practices explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. I also understand this office has the right to change this notice at any time. My signature below constitutes my acknowledgment of this office's Notice of Privacy Practices and assignment of benefits.

X | **X**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE DATE | WITNESS

I WILL BE GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY PROCEDURES TO BE PERFORMED AND THE RISKS AND HAZARDS INVOLVED. I (WE) HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT AND UNDERSTAND THAT NO WARRANTY OR GUARANTEE HAS BEEN MADE TO ME TO GIVE THIS INFORMED CONSENT. I (WE) CERTIFY THIS FORM AND THE EXAMINATION HAS BEEN FULLY EXPLAINED TO ME AND I (WE) HAVE READ IT, OR HAVE HAD IT READ TO ME (US), THAT THE BLANK SPACES HAVE BEEN FILLED IN AND THAT I (WE) UNDERSTAND ITS COMMENTS AND GIVE CONSENT TO THE DIAGNOSTIC EXAMS TO BE PERFORMED ON ME.

X | **X**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE DATE | PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE DATE

The following questions are a **GOVERNMENT REQUIREMENT** for the HITECH Act
(Health Information Technology for Economical and Clinical Health)
These questions are for government program compliance only (WE are Required to ask these)

6. Ethnic background? ☐ Unknown ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ No Response

7. Race? ☐ Unknown ☐ American Indian/Native American ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Other:

8. Language? ☐ Unknown ☐ Arabic ☐ Cantonese ☐ English ☐ Hebrew ☐ Japanese ☐ Korean ☐ Mandarin ☐ Russian ☐ Spanish ☐ Other:

9. List any medications you are currently taking:

10. List any food or drug/medication allergies:

11. **(AGES 13 AND OLDER)**

Smoking History? ☐ Unknown ☐ Smoker-Every Day ☐ Smoker-Occasional ☐ Former Smoker ☐ Never a Smoker

12. **(FEMALE'S ONLY - AGES 40-69)**

Have you ever had a mammogram to screen for breast cancer? ☐ YES ☐ NO

13. **(AGES 50-75)**

Have you ever had a colonoscopy to screen for colorectal cancer? ☐ YES ☐ NO

14. **(AGES 64 AND OLDER)** Have you ever had a pneumonia (pneumococcal) vaccine? ☐ YES ☐ NO