Albany Surgical & Surgery Center, PC

PATIENT REGISTRATION FORM

OFFICE USE ONLY: CHART #_____ Dr. _____

Date _____

Name _____ Preferred Name _____
(first) (middle) (last)

Address _____ Apt #_____

City _____ State _____ Zip _____

Phone: Home #_____ Cell/Alt. #_____ Work #_____

SS #___ – ___ – _____ Date of Birth ___/___/_____ ☐ Male ☐ Female

Marital Status (*check one*) ☐ Single ☐ Married, Spouse's Name _____

☐ Divorced ☐ Widowed ☐ Domestic Partner

Ethnicity/Race (*check one*) ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

☐ Other _____

Email address _____@_____

Primary Care Physician _____ Referring Physician _____

Are you employed? ☐ Retired ☐ Disabled ☐ Unemployed

If employed, employer: _____

Employer's Address: _____

►►► ***If patient is a minor, please provide employment information for responsible party*** ◄◄◄

In case of emergency contact _____

Relationship _____ Phone #_____

DO YOU HAVE INSURANCE? ☐ Y ☐ N

Primary Insurance _____ Phone #_____

Insured Name _____ SS #___ – ___ – _____ DOB ___/___/_____

ID #_____ Group #_____

Relationship to Insured (*check one*) ☐ Self ☐ Spouse ☐ Child ☐ Other _____

* *

Secondary Insurance _____ Phone #_____

Insured Name _____ Policy Holder's Phone #_____

ID #_____ Group #_____

Relationship to Insured (*check one*) ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient Consent for Use and Disclosure of Protected Health Information

I acknowledge that I have received or have been offered a copy of the Albany Surgical, PC Notice of Patient Privacy Practices. I acknowledge that a copy is posted in the patient waiting area & available to access for my personal review.

With my consent, Albany Surgical, PC may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Albany Surgical, PC Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Albany Surgical, PC may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care. I have the right to request that Albany Surgical, PC restrict how it uses or discloses my PHI to carry out TPO.

Do you give our office permission to discuss your medical record with anyone?

___ Yes ___ No

If "Yes," Name and Relationship: _____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Albany Surgical, PC may decline to provide treatment to me.

_____

Patient's Name or Legal Guardian (Please Print)

_____ _____

Signature of Patient or Legal Guardian Date