



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 \_\_\_\_\_

What language do you speak? \_\_\_\_\_

Do you have email? Y N Would you like to be web enabled? Y N
(web enabled means that you can go to our patient portal & review your records, request refills, appointments, etc.)

If so, what is your email address \_\_\_\_\_ @ \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Referred to us by: Family/Friend Internet TV Ad Facebook Other (please specify) \_\_\_\_\_

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 # \_\_\_\_\_

Is your visit the result of an accident? Y N If Yes Work Auto Home Date of Injury \_\_\_\_\_

If auto related, do you have med pay on your automobile insurance? If so, with which ins. co.? \_\_\_\_\_

DO YOU HAVE INSURANCE? Y N

If your insurance is NOT in your name (ex: if the Policy Holder is your spouse or parent), we MUST have the following information:

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 \_\_\_\_\_

***If and only if you have ANY form of Medicare Insurance, you MUST answer the questions in the box:***

\*\*\*\* (If this does not apply to you, please skip this part and sign and date the bottom of this page) \*\*\*\*

- 1) Are you entitled to Medicare based on  age  disability  ESRD (End Stage Renal Disease/Dialysis)
- 2) Are you currently employed  Yes  No If "No," date of retirement: \_\_\_\_\_  
If "yes," name and address of employer: \_\_\_\_\_  
\_\_\_\_\_
- 3) Is your spouse currently employed?  Yes  No If "No," date of retirement: \_\_\_\_\_  
If "yes," name and address of employer: \_\_\_\_\_  
\_\_\_\_\_
- 4) Do you have group health coverage based on your or your spouse's employment (for example: BCBS, United Healthcare, Cigna, etc.)?  Yes  No
- 5) Does the employer that sponsors your group health coverage employ 100 or more employees?  
 Yes (group health is primary)  No (Medicare is primary)
- 6) Are you currently under hospice care?  Yes  No If "Yes," name and phone number of hospice provider:  
\_\_\_\_\_  
\_\_\_\_\_

**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