PATIENT REGISTRATION FORM

OFFICE USE ONLY: CHART #__________ Dr. __________

Date __________

Name __________ (first) (middle) (last) Preferred Name __________

Address __________ Apt #__________ or Lot #__________

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 If not, why not? __________
(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? ☐ Y ☐ N Where are you employed? __________

Employer's Address: __________

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

In case of emergency contact __________ Relationship __________ Phone #__________

Local Pharmacy Name & Address __________

**Do you have a mail order pharmacy? ☐ Y ☐ N If "Yes," which one __________

What is the primary reason for your visit? __________

**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.?*** __________

Have you previously been treated for this condition?

☐ Y ☐ N If "Yes," when and by whom __________

Were ☐ X-rays, ☐ MRI, ☐ CT scans, or ☐ endoscopies obtained? ☐ Y ☐ N If "Yes," where? __________

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 #__________

Address __________ City __________ State ______ Zip __________

Insured Name __________ SS #______ – _____ – ______ DOB ____/____/______

ID #__________ Group #__________

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

* *

Secondary Insurance __________ Phone #__________

Address __________ City __________ State ______ Zip __________

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.

______________________ ______________________ ______________________

Signature of Patient or Legal Guardian | Patient's Name or Legal Guardian (Please Print) | Date