Albany Surgical & Surgery Center, PC

PATIENT REGISTRATION FORM

OFFICE USE ONLY: CHART #____________ Dr. ____________

Date ____________

Name ____________ (first) (middle) (last) Preferred Name ____________

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 "<u>NOT</u>" in your name (ex: if the Policy Holder is your spouse or parent), we <u>MUST</u> 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