

## PATIENT REGISTRATION FORM

|                                                                                                                                                                                                                          |                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Patient Name (Last, First, Middle) _____</p> <p>Patient Address: _____</p> <p>Apt #: _____</p> <p>City _____ State _____ Zip _____</p> <p>Home Phone# _____</p> <p>Cell Phone#: _____</p> <p>Email Address: _____</p> | <p>Marital Status: Single / Married / Separated / Divorced / Widowed</p> <p>Social Security # _____ DOB: _____</p> <p>Race: _____</p> <p>Ethnicity: _____</p> <p>Language: _____</p> |
| <b>EMPLOYMENT INFORMATION</b>                                                                                                                                                                                            | <b>EMERGENCY CONTACT (Provide Different Phone Number)</b>                                                                                                                            |
| <p>Employer: _____</p> <p>Occupation: _____</p> <p>Address: _____</p> <p>Work Phone: _____</p>                                                                                                                           | <p>Relationship to patient: _____</p> <p>Name: _____</p> <p>Address: _____</p> <p>Cell Telephone: _____</p> <p>Work Telephone: _____</p>                                             |
| <b>MEDICAL PROVIDER INFORMATION</b>                                                                                                                                                                                      | <b>TO WHOM MAY WE DISCUSS YOUR MEDICAL INFO WITH?</b>                                                                                                                                |
| <p>Family/Primary Care Physician: _____</p> <p>Address: _____</p> <p>Telephone: _____</p> <p>Gynecologist: _____</p> <p>Address: _____</p> <p>Telephone: _____</p> <p>Who referred you to our office? _____</p>          | <p>Name: _____</p> <p>Telephone: _____</p><br><p>Name: _____</p> <p>Telephone: _____</p>                                                                                             |

### **Advance Care Plan** **(Age 65 and OLDER ONLY)**

**An advanced care plan is a legal document which advises someone of your wishes  
in the event that you are unable to make your own health care decisions and  
gives them permission to carry out your wishes.**

- 1. Does the patient have Advanced Directives?    Yes \_\_\_\_ No \_\_\_\_**
- 2. What is the patient's DNR status? Resuscitation: Yes \_\_\_\_ No \_\_\_\_**
- 3. Does the patient wish to have mechanical ventilation?    Yes \_\_\_\_ No \_\_\_\_**
- 4. Does the patient wish to be provided nutrition or hydration via feeding tube?    Yes \_\_\_\_ No \_\_\_\_**
- 5. Does the patient wish to receive antibiotics?    Yes \_\_\_\_ No \_\_\_\_**
- 6. Is the patient an organ donor?    Yes \_\_\_\_ No \_\_\_\_**

**AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY**

I (or designated guardian) authorize Physician to provide treatment and release medical information to my insurance as may be necessary for payment of physician claims. I (or designated guardian) hereby authorize payment directly to Physician of the benefits otherwise payable to me but not to exceed regular charges for physician claims. I (or designated guardian) understand that I am financially responsible to the Physician for charges not covered by my insurance.

X \_\_\_\_\_

**PATIENT AND/OR GUARDIAN SIGNATURE****DATE****AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize Physician to supply to another Physician involved in my medical care a copy of necessary medical records and/or test results requested by the Physician but ordered by my Primary Care Physician. I understand this is for the release of medical information only. If I am a managed care subscriber, I authorize my Physician to allow my Managed Care Organization access to my chart for Quality Review Purposes.

X \_\_\_\_\_

**PATIENT AND/OR GUARDIAN SIGNATURE****DATE****MEDICARE PATIENTS (MUST COMPLETE THE NEXT TWO SECTIONS)**

**MEDICARE BENEFITS** Patient's certification, authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVI of the Social Security Act is correct. I authorize any holder or medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for physician claims and other related medical claims. I request that payment of claims be made on my behalf for authorized benefits under my health insurance. I hereby authorize payment directly to my Physician for insurance benefits otherwise payable to me. Payments are not to exceed the balance due of the practice's regular charges for these claims. I understand that I am financially responsible to my Physician for charges not covered by this authorization. I understand that my Physician will bill HCDA using the term "signature on file" and am aware that my signature as written below constitutes that "on file "signature".

X \_\_\_\_\_

**PATIENT AND/OR GUARDIAN SIGNATURE****DATE**

**MEDIGAP BENEFITS** I hereby give my Physician permission to ask for Medigap payments for my medical care. I understand that my Medigap Insurer needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to my Medigap Insurer. I request that payment of authorized Medigap benefits be made to Infectious Diseases Associates, P.C. on my behalf for any services furnished me by my Physician. I authorize any holder of medical information about me to release Medigap Insurer any information needed to determine these benefits of the benefits payable for related services.

X \_\_\_\_\_

**PATIENT AND/OR GUARDIAN SIGNATURE****DATE****CONSENT OF TREATMENT FOR MINOR/INCAPACITATED PATIENTS**

I hereby authorize Physician to provide treatment to \_\_\_\_\_. Patient is unable to consent to medical treatment because minor child/other \_\_\_\_\_.

X \_\_\_\_\_

**SIGNATURE OF GUARDIAN**

X \_\_\_\_\_

**NAME OF GUARDIAN**

X \_\_\_\_\_

**WITNESS SIGNATURE****DATE:** \_\_\_\_\_

**CONSENT TO SEND APPOINTMENT REMINDERS**

I hereby consent to Infectious Diseases Associates, PC use of my medical information for the purpose of sending Appointment Reminders, unless and until revoked by me in writing.

X \_\_\_\_\_  
**PATIENT AND/OR GUARDIAN SIGNATURE**

**DATE:** \_\_\_\_\_

**CONSENT TO OBTAIN PHARMACY INFORMATION ELECTRONICALLY:**

I hereby consent to allow Infectious Diseases Associates, PC to obtain my pharmacy information which includes medications, dosages, and prescriptions filled from participating pharmacies. I consent to their sending electronic prescriptions. This helps to reduce medication error while providing your physician with your most up-to-date medication profile.

X \_\_\_\_\_  
**PATIENT AND/OR GUARDIAN SIGNATURE**

**DATE:** \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY**

I. I acknowledge receipt of Notice by signature

\_\_\_\_\_  
Patient/Guardian Name (Printed)

\_\_\_\_\_  
Patient/Guardian Name (Signature)

\_\_\_\_\_  
Date

II. Signature Unable to be Obtained due to:

☐ Patient Refused

☐ Patient Incapable of Signing (explain) \_\_\_\_\_

☐ Other (explain) \_\_\_\_\_

\_\_\_\_\_  
Office Staff Signature

\_\_\_\_\_  
Date

NOTE: We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance. We may use your PHI for purposes of calling your home or alternate location and leaving a message or voice mail or in person in reference to any items that assist the practice in carrying out TPO (Treatment, Payment and Health Care Operations), such as appointment reminders, insurance items and any calls pertaining to your clinical care, including laboratory results among others, unless or until revoked by you in writing. We may mail to your home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, unless or until revoked by you in writing.