



PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES					
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)			ADDRESS		
CITY, STATE		ZIP	HOME PHONE	CELL PHONE	
PATIENT DATE OF BIRTH	PATIENT SSN	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
PATIENT EMPLOYER NAME		PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE	
INSURED/RESPONSIBLE PARTY INFORMATION			RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian		
NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER	
INSURANCE INFORMATION					
PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
PRIMARY DOCTOR/FAMILY DOCTOR			REFERRING DOCTOR		
IN CASE OF EMERGENCY CONTACT			RELATIONSHIP	PHONE NUMBER	

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.	
SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

RELEASE OF INFORMATION		
I understand that:		
<ul style="list-style-type: none"> • Once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information. • I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524). • my records are protected and cannot be disclosed without written permission • this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department. 		
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I _____ have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Sign: _____

Date: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name} Relationship

{Please Print Name} Relationship

{Please Print Name} Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT OF

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 (Please Print Name) Relationship

 (Please Print Name) Relationship

 (Please Print Name) Relationship

We attempt to maintain accurate records of our Notice of Privacy Practices, but acknowledgment could not be obtained. I have:

Individual refused to sign
 Communications barrier prohibited obtaining the acknowledgment
 An emergency situation prevented us from obtaining acknowledgment
 Other (Please Specify) _____