PATIENT REGISTRATION FORM

ADULT

Thank you for completing this Patient Registration Form. Patients are required to complete the Registration Form as a new patient and annually as our established patient. Your Protected Health Information (PHI) is protected by the 1996 HIPAA Act. Please notify this office when any changes are made to this information.

REGISTRATION DATE: ___ ___ ___ ___ ___ ___ ___ ___
Month Day Year

SECTION I. PATIENT DEMOGRAPHIC INFORMATION

First Name | **Middle Name/Initial** | **Last Name, Any Previous Name(s)**

Is this the patient's legal name? ☐ Yes ☐ No **If NO, What is legal name?** ______________________

Current Address

______________________ ______ ______________ ______ ______
Street Address **Apt/Unit/Floor** **City** **State** **Zip Code**

Phone Numbers

Primary ( ) __________________ ☐ Home ☐ Cell

Secondary ( ) __________________ ☐ Home ☐ Cell

Work ( ) __________________

Email Address

____

☐ None

Primary Care Provider

____

☐ None

Patient's Date of Birth

__ __ __ __ __ __ __ __
Month Day Year

Age ___

Patient's Gender
☐ Female ☐ Male
☐ Transgender

What is patient's current marital status? CHECK ONE
☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed

Social Security Number
__ __ __ - __ __ - __ __ __ __

SECTION II. PATIENT EMPLOYMENT INFORMATION

Is patient currently employed?

☐ Yes PLEASE ANSWER EMPLOYMENT QUESTIONS BELOW
☐ No PLEASE SKIP TO SECTION III
☐ PATIENT IS A STUDENT
☐ PATIENT IS DISABLED

Employment Status ☐ Full-time ☐ Part-time ☐ Retired ☐ Other ____________

Is primary health insurance with this employer? ☐ Yes ☐ No

____
Primary Employer Name

Patient's Current Occupation ______________________

List Any Other Employers for Patient

____
Mailing Address

____
Employer Name Telephone Number

____
City State Zip Code

SECTION III. PATIENT EMERGENCY CONTACT INFORMATION

____
Contact Name

____
Relationship to Patient

Contact Number ( ) ____________ ☐ Home ☐ Cell ☐ Work

Alternate Phone Number ( ) ____________ ☐ Home ☐ Cell ☐ Work

SECTION IV. PATIENT INSURANCE INFORMATION

Patient currently covered by health insurance? ☐ **Yes** ☐ **No** **IF YES, PLEASE PROVIDE CARD(S) TO RECEPTIONIST**

PRIMARY Insurance Plan Name ______________________

☐ **SEE CARD (skip to next section)**

Member/Policy/ID/Claim # ____________ Group Name or # ____________ Co-Payment $ ________

☐ **SAME AS PATIENT (skip to next section)**

Subscriber Name ______________________ Subscriber Social Security Number __ __ __ - __ __ - __ __ __ __

Subscriber Address ______________________

Subscriber Date of Birth ___ ___ ___ ___ ___ ___ ___ ___
Month Day Year

Subscriber Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other ____________

SEE REVERSE SIDE

FIRELANDS Physician Group

PATIENT REGISTRATION FORM

ADULT

SECONDARY Insurance Plan Name ____________________

☐ **SEE CARD (skip to next section)**

Member/Policy/ID/Claim # ____________ Group Name or # ____________ Co-Payment $ ________

☐ **SAME AS PATIENT (skip to next section)**

Subscriber Name ____________________ Subscriber Social Security Number __ __ __ - __ __ - __ __ __ __

Subscriber Address ____________________

Subscriber Date of Birth ___ ___ (Month) ___ ___ (Day) ___ ___ ___ ___ (Year) Subscriber Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other ____________

SECTION V. OTHER PATIENT INFORMATION

ETHNICITY (CHECK ONE)

- ☐ Hispanic Origin
- ☐ Non-Hispanic Origin
- ☐ Don't Know
- ☐ Declines to Disclose

RACE (CHECK ONE)

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Black or African American
- ☐ White
- ☐ Hispanic
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ Unreported/Declines to Disclose

Patient's primary speaking language? (CHECK ONE)

- ☐ English ☐ Italian
- ☐ Spanish ☐ Chinese
- ☐ German ☐ Other (SPECIFY) ____________

Does the patient require a translator for medical care?

☐ Yes ☐ No

Does the patient have an advance directive?

☐ Yes ☐ No

*If yes, please make sure current document is on file.

SECTION VI. PATIENT MEDICATION INFORMATION

Patient's Pharmacy Name and Location(s):

____

CONSENT TO OBTAIN MEDICATION HISTORY

By signing this form, you authorize Firelands Physician Group to obtain your medication history from a service called *SureScripts ePrescribing.* This consent includes any prescription medications used to treat AIDS/HIV, mental health or psychiatric conditions. We will obtain approximately a six month medication history. This information will become part of your medical record.

Patient Signature ____________________

SECTION VII. PATIENT REGISTRATION AUTHORIZATION

I certify that the above registration information is true to the best of my understanding and knowledge. I authorize Firelands Physician Group [FPG] to release any information required to process my claims. I am assigning insurance benefits to be paid directly to FPG. I understand that I am financially responsible for any account balances and costs incurred in collecting those balances. I agree to permit authorized FPG personnel to perform diagnostic and therapeutic procedures that my treating provider(s) deem necessary for care. By signing below I agree to permit x-rays, laboratory tests, photographs for treatment purposes, routine medical treatment (for example, medications, injections, vaccinations, drawing blood for tests), emergency procedures as necessary and hospital services performed at the request of providers arising in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks and complications associated with such treatment or procedures and I have given my consent. I understand that FPG is a teaching organization and that healthcare personnel in training may assist, be present and participate in providing my care and that my medical records may be used for education purposes.

Patient Printed Name ____________________

Patient Signature ____________________ **Date** ____________

Please return completed form, photo identification, and health insurance card(s) to receptionist.