PATIENT REGISTRATION

DATE_____ FOR INTERNAL USE ONLY
PATIENT NUMBER_____

PATIENT INFORMATION

SOCIAL SECURITY #_____ HOME ADDRESS_____

FIRST NAME_____ MIDDLE_____ _____

LAST NAME_____ CITY_____ STATE_____ ZIP_____

SEX_____ DATE OF BIRTH_____ EMAIL_____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED HOME PHONE (_____) _____

WORK PHONE (_____) _____

(CHECK ONE)
☐ EMPLOYED ☐ RETIRED CELL PHONE (_____) _____

☐ FULL TIME STUDENT ☐ OTHER REFERRING PHYSICIAN_____

EMPLOYER_____ HOW DID YOU HEAR OF US?_____

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURED / CARD HOLDER'S NAME_____

RELATIONSHIP_____ DOB_____ SOC. SEC. #_____

SECONDARY INSURANCE INFORMATION

INSURED / CARD HOLDER'S NAME_____

RELATIONSHIP_____ DOB_____ SOC. SEC. #_____

EMERGENCY CONTACT

RELATIONSHIP_____ SEX_____

FIRST NAME_____ MIDDLE_____ HOME PHONE (_____) _____

LAST NAME_____ WORK PHONE (_____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY #_____ SEX_____ DATE OF BIRTH_____

RELATIONSHIP_____ DAYTIME PHONE (_____) _____

FIRST NAME_____ MIDDLE_____ EMPLOYER_____

LAST NAME_____ ADDRESS_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

CITY_____ STATE_____ ZIP_____

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____ _____
SIGNATURE (Patient or Parent if Minor) DATE

UNIVERSITY MEDICAL GROUP

Patient Privacy Questionnaire and Notification

Patient Name:_____ Date of Birth:_____

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

Contact Information:

I would prefer to be contacted at: _____Home #_____

_____Cell #_____

_____Work #_____

_____Other #_____

_____May ONLY leave information with me. (If you check here, no other choice should be marked).

_____May leave appointment reminders on my answering machine/voicemail.

_____May leave lab results on my answering machine/voicemail.

_____May leave general questions/information on my answering machine/voicemail.

_____May send confidential messages regarding appointments, lab results, or general messages to your patient portal account

_____May leave a message with a call back number only.

Please list the name of the individual and relationship of anyone we may give information to:

Name:_____Relationship:_____

Name:_____Relationship:_____

_____May leave appointment reminders with the above listed person

_____May leave lab results with the above listed person

_____May leave general questions/information with the above listed person

_____May discuss billing information with the above listed person

_____I prefer that all healthcare messages be given to the above listed person

If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

Signature of Patient_____ Date_____