DATE ______________________

PATIENT REGISTRATION

PATIENT INFORMATION

SOCIAL SECURITY # ______________________

FIRST NAME ______________ MIDDLE INITIAL ____

LAST NAME ______________ MAIDEN NAME ________

SEX ______ DATE OF BIRTH _____/_____/_____

MARITAL STATUS ________ ETHNICITY ________

BILLING ADDRESS ______________________

CITY ______________ STATE ____ ZIP ______

HOME PHONE (____)______________ ❒ *Please check*

CELL PHONE (____)______________ ❒ *preferred method*

WORK PHONE (____)______________ ❒ *of contact.*

E-Mail ______________________ ❒

CHECK ONE ❒ Unemployed ❒ Retired ❒ Student ❒ Employed

EMPLOYER & ADDRESS ______________________

INSURANCE INFORMATION – Please present card(s)

PRIMARY INS. ❒ Commercial ❒ Medicare ❒ Medicaid ❒ Comp

INSURANCE COMPANY ______________________

POLICY # ______________________

CARDHOLDER'S NAME ______________ DOB ______

RELATIONSHIP TO PATIENT ______________________

CARDHOLDER'S EMPLOYER & ADDRESS ______________________

____

SECONDARY INS. ❒ Commercial ❒ Medicare ❒ Medicaid ❒ Comp

INSURANCE COMPANY ______________________

POLICY # ______________________

CARDHOLDER'S NAME ______________ DOB ______

RELATIONSHIP TO PATIENT ______________________

CARDHOLDER'S EMPLOYER & ADDRESS ______________________

Primary Pharmacy: ______________________ **Secondary Pharmacy:** ______________________

FOR PEDIATRIC PATIENTS ONLY: Please check each name that has custody/permission to contact. Legal docs may be requested.

❒ Mother ______________ Phone ______________ Maiden Name ______________

❒ Father ______________ Phone ______________

GUARANTOR / RESPONSIBLE PARTY (If not SELF, then the Insurance Subscriber or Parent/Guardian if minor)

SOCIAL SECURITY # ______________ SEX ______ RELATIONSHIP TO PATIENT ______________

FIRST NAME ______________ MIDDLE ______ LAST NAME ______________ DOB ______

HOME ADDRESS ______________________ HOME PHONE (____) ______________

______________________ WORK PHONE (____) ______________

CITY ______________ STATE ____ ZIP ______ CELL PHONE (____) ______________

EMERGENCY CONTACT (Parent/Guardian if Minor, in addition to Guarantor)

FIRST NAME ______________ MIDDLE ______ LAST NAME ______________DOB______

SEX ______________ RELATIONSHIP TO PATIENT ______________________

HOME PHONE (___) ______________ WORK PHONE (___) ______________ CELL PHONE (___) ______________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby 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.

Please check one and initial: ❒ I authorize ________ ❒ I do not authorize ________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize the release of any information to my current insurance company or third party contractor upon their request.

Please check one and initial: ❒ I authorize ________ ❒ I do not authorize ________

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________, acknowledge that I have received a copy of Clifton Fine Hospital's notice of Privacy Practices. This Notice describes how Clifton Fine HOspital may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Please check one and initial: ❒ I received __________ ❒ I do not receive __________

If this patient is a minor, the following individuals may accompany my child to appointments in my absence.

	Name of Individuals	Relationship	Phone
1.			
2.			
3.			

Or, check here if applicable: ❒ I do not authorize any individuals __________

SIGNATURE (Patient or Parent/Guardian if Minor) ______________ Initials ______ RELATIONSHIP TO PATIENT (if Minor) ______________ DATE ______