

Today's Date: \_\_\_\_\_

Patient ID # \_\_\_\_\_ [for office use only]

Referring Physician \_\_\_\_\_

**PATIENT REGISTRATION FORM**

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M  F  Social Security #: \_\_\_\_\_

For Minors please indicate responsible Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State/Zip

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Email: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Marital Status: Single  Married  Widowed  Separated  Divorced

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

**How did you hear about us?**

Please check as many corresponding boxes that apply:

- |  |   |
|--|---|
| Website <input type="checkbox"/>                 | Facebook <input type="checkbox"/>                                 |
| Google/Yahoo/Bing <input type="checkbox"/>       | Other Internet Ad <input type="checkbox"/>                        |
| Newspaper/Magazine Ad <input type="checkbox"/>   | Direct mailing (letter, post card, etc.) <input type="checkbox"/> |
| Friend or family _____ <input type="checkbox"/>  | Physician <input type="checkbox"/>                                |
| Other (e.g., CVS) _____ <input type="checkbox"/> |   |

I would like to receive email newsletters, general health tips and information from Barnabas Health: Yes  No

If Yes, please provide email address: \_\_\_\_\_

**Responsible Party**

**Complete Only if Patient is Not the Responsible Party**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: ( ) \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_

**Insurance Information (Present Insurance Card(s) to Receptionist)**

**Primary Insurance:** \_\_\_\_\_ Policy/ID #: \_\_\_\_\_

Group/Plan #: \_\_\_\_\_ Relationship to Subscriber: \_\_\_\_\_

Effective Date of Primary Insurance: \_\_\_\_\_

**Subscriber Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: ( ) \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Policy/ID #: \_\_\_\_\_

Group/Plan #: \_\_\_\_\_ Relationship to Subscriber: \_\_\_\_\_

Effective Date of Secondary Insurance: \_\_\_\_\_

**Subscriber Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: ( ) \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_

**Demographic Information Request**

In order to comply with federal regulations, we are required to ask you for the following information:

**Race**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Patient Declined

**Ethnicity**

- Hispanic or Latino
- Not Hispanic or Latino
- Patient Declined

**Advance Directives**

Do you have a health care proxy/living will?  Yes  No Do you want to discuss this with your physician?  Yes  No

**Smoking Status**

Please indicate your smoking history:

- Never Smoked
- Past Smoker
- Current smoker – Indicate how many and how often you smoke \_\_\_\_\_

**Communication Preferences**

I understand that the staff and/or physicians of Barnabas Health Medical Group (“BHMG”) may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Preferred Language \_\_\_\_\_ Preferred method for communication:  Home  Work  Cell

Can we leave a message on machine or with whoever answers? (Circle **Yes** or **No**) **Home** Y / N **Work** Y / N **Cell** Y / N

**DO NOT CALL:**  Home  Work  Cell

**Disclosure to Designated Family/Friends/Caregivers**

I allow BHMG to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing any time.

_____	_____	_____	_____
Print Name	Date of Birth	Relationship	Phone Number

_____	_____	_____	_____
Print Name	Date of Birth	Relationship	Phone Number

**Preferred Pharmacy**

Please indicate your preferred Pharmacy /Pharmacies below:

Pharmacy Name: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

(Indicate City and Cross Streets, Zip Code, if known)

Pharmacy Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

(Indicate City and Cross Streets, Zip Code, if known)

**Authorization to Access Electronic Prescription Records**

I authorize Barnabas Health Medical Group (“BHMGM”) and its affiliated providers to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my BHMGM medical record.

**Health Information Exchange (HIE)**

BHMGM also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize BHMGM and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs’ policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to “opt-out” of having my information shared through HIEs, and instructions on how to do that can be found in the BHMGM Notice of Privacy Practices, the HIE brochure which is available from participating BHMGM offices, or may be requested from BHMGM’s Privacy Officer.

**Authorization for Photographs and Release for use in Medical Records**

I hereby authorize and consent to the taking of photographs and moving pictures of me by BHMGM, its agents or employees. I hereby authorize and consent to the use and storage of such photographs and moving pictures for identification purposes and as part of my medical record.

I hereby release BHMGM, its medical staff, agents and employees from all liability related to the making, storage, and use of such photographs and moving pictures for identification purposes and as part of my medical record.

**Release and Assignment of Benefits**

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the providers in BHMGM for services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments and benefits services that are out of network, denied and/or not covered by my health insurance plan. I authorize BHMGM or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

**Consent to Treat**

I, the undersigned, voluntarily consent to and authorize BHMGM through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my BHMGM physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

**Acknowledgments and Agreement**

- I acknowledge that I have been advised of my right to an Advance Directive.
- I acknowledge receipt of the BHMGM Financial Policy, and agree to all the terms and conditions contained therein.
- I acknowledge receipt of the Notice of Privacy Practices.
- I agree to allow access to my electronic prescription records as described above.
- I agree to the release and assignment of benefits as described above.

- I agree to treatment as described above.
- I have read this form, my questions have been answered, and I understand and agree to its content.

\_\_\_\_\_  
Patient/Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by Authorized Representative, print name of Signatory

\_\_\_\_\_  
Relationship to Patient/Authority to Sign for Patient