Healthcare South, P.C.
Caring and Partnership in Family Health

Patient Registration Form

PATIENT INFORMATION

Last Name: _______________________________ First Name: _________________________________ Middle: ________________

Gender: _________________ Name patient prefers to be addressed by: ____

Pronoun preference: ________________ Race*: _____________ Ethnicity*: _______________Language*: ______________

Street: ____ APT/P.O. Box: _____________________

City: ____State: ____________________ Zip Code: _____________________

Home Phone: ___________________________Cell: _____________________________ Work: ____________________________

Date of Birth: __________________________ Referred by: ____

CFP Primary Care Provider of Choice: ____

Email address (over 18): ____

*** new Federal Regulations require us to collect this information**

IF MINOR (UNDER 18)

<u>1st Parent:</u>

First Name: _________________________________ Middle: _____________ Last Name: __________________________________

Occupation: ____DOB: ____

Street: _____________________________________City: _____________________ State: _________ Zip Code: _______________

Home Phone: ___________________________Cell: _____________________________ Work: ____________________________

Email Address: ____

<u>2nd Parent:</u>

First Name: _________________________________ Middle: _____________ Last Name: __________________________________

Occupation: ____DOB: ___________________ ___________________

Street: _____________________________________City: _____________________ State: _________ Zip Code: _______________

Home Phone: ___________________________Cell: _____________________________ Work: ____________________________

Email Address: ____

<u>With whom does this patient reside?</u>

First Name: _________________________________ Middle: _____________ Last Name: __________________________________

Street: _____________________________________City: _____________________ State: _________ Zip Code: _______________

Email address: ____

PRIMARY INSURANCE COMPANY INFORMATION

Company Name: ______________________________________ Group #: _______________ Effective Date: _______________

ID#: ____ Co-pay Amount: ______________________________

Subscriber Full Name: ____ Gender: _____________ DOB: ___________________

Street: ____ Apt/PO Box: _________________________

City: ____State: _______________Zip Code: _______________________

Insured's Employer: ____

Secondary Insurance (Name & ID #): ____

FAMILY MEMBERS/Siblings:

Last Name: ____________________ First: ___________________ DOB: ____________ Relationship: ____________________

Last Name: ____________________ First: ___________________ DOB: ____________ Relationship: ____________________

PAYMENTS OF BENEFITS

I authorize payment of benefits as determined by the insurance company directly to:

Physician Yes ☒ No ☐

I understand even if I have checked "yes" above I may still be responsible for any amounts not paid by my insurance company in the event charges made are not reasonable and customary.

Patient/ Legal Guardian Signature: ____ **Date:** ___________________

MEDICAL RELEASE AUTHORIZATION

Insured party must sign for all claims. Dependent patient must sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested about processing my claim. I certify the information I furnished is true and correct. I know it is a crime to complete this form with false information or important information is omitted.

Patient/ Legal Guardian Signature: ____ **Date:** ___________________

HIPAA - PRIVACY STATEMENT

By signing, I am consenting to Healthcare South, P.C.'s and disclosure of my PHI to carry out treatment, payment and health care operations, and to the use of phone or mail contact as outlined on the HIPAA notice previously present to me and/or available on our website. A complete copy can be requested in person.

Patient/ Legal Guardian Signature: ____ **Date:** ___________________

Does patient/legal guardians authorize the medical providers of this practice to consent to routine and emergency medical care of this patient? Yes ______ No ______

____ __________________________ _________________

Signature **Date** **Time**