PATIENT REGISTRATION FORM

Reason for today's visit: ____

Was this a result of a Motor Vehicle Accident? ❑ Yes ❑ No Date of Accident: ___________

Was this a result of a Job Injury? ❑ Yes ❑ No Date of Injury: _________________

Patient's Name: ____ Sex: ❑ Male ❑ Female

Date of birth: _____/_____/_____ SSN: _____-____-_______

Current Street Address:_________________________________ Apt#/Floor/Suite#:______

City: _______________________ State: _____ Zip: _______

Home Phone: (_____) _____-________ Cell Phone: (_____) _____-________

Best form of contact? ❑ Home ❑Cell E-Mail Address: _________________________

Preferred Pharmacy (name and street): ____

How did you hear about us? ____

Primary Care Provider:______________________

Emergency Contact Info

Name: ______________________ Contact Phone: (_____) _____-_____

Relationship to patient: _________________

For any patient under the age of 18, please fill out this section*:*

Responsible Party (of the patient) Name:

____ Sex: ❑ Male ❑ Female

Current Street Address:_________________________________ Apt#/Floor/Suite#:______

Date of Birth: ____/_____/_____

City: _______________________ State: _____ Zip: _______

Home Phone: (_____) _____-________ Cell Phone: (_____) _____-________

Primary Insurance

Insurance Company: ______________________

Policy #: ________________Group # ___________

Subscriber Name_________________ DOB_______

Patient Relationship to Subscriber_______________

Secondary Insurance

Insurance Company: ___________________

Policy #: _____________ Group # _________

Subscriber Name_____________ DOB______

Patient Relationship to Subscriber__________

AUTHORIZATION AND RELEASE

Authorization for Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent.

Authorization for use of e-mail/cell phone: I voluntarily consent to the use of my personal e-mail and/or cellular phone via voice or text to receive newsletters or notifications. This is NOT to be used for my private medical records or health information.

Assignment of Insurance Benefits: I authorize payment directly to THE DOCTORS' OFFICE OF WEST CALDWELL for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co pays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize THE DOCTORS' OFFICE OF WEST CALDWELL to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of THE DOCTORS' OFFICE OF WEST CALDWELL I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE: ____ **DATE:** ______________

PARENT/GUARDIAN SIGNATURE: _____________________ _____________________________ **DATE:** ______________

CONSENT FOR NOTIFICATION OF TEST RESULTS/MEDICAL INFORMATION

I give permission to THE DOCTORS' OFFICE OF WEST CALDWELL to:

1. Follow- up phone calls or call backs in regards to care at The Doctors' Office of West Caldwell using this phone #: _______ _____
2. Leave message on my answering machine: (**circle one**) Yes/No
3. Discuss my health information with the following people ____

PATIENT SIGNATURE: ____ **DATE:** _________________