Patient Registration Form

Patient Information

Last Name:	First Name:	MI:
Address:		
City/State/Zip:		
Social Security Number:	Date of Birth:	Gender assigned at birth: ◯ Male ◯ Female
Employer (include address):		
Emergency Contact:	Emergency Contact Phone:	Relationship to Patient:

Primary Language: ◯ English ◯ Spanish ◯ Other (Please specify):	Hispanic / Latino: ◯ Yes ◯ No	Race: ◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Native Hawaiian or Other Pacific Islander ◯ White
Pharmacy Name:		Pharmacy Phone:
Pharmacy Address:		

Parent / Guardian Information

PARENT / GUARDIAN #1 ☐ Check here if this is the patient's guarantor (person responsible for charges not covered by insurance).

Last Name:		First Name:	MI:
Address:			
City/State/Zip:		Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:	Email Address:

Preferred Contact: ◯ Home Phone ◯ Mobile Phone ◯ Work Phone ◯ MAIL ONLY	OK to leave a message regarding your medical care on preferred phone? ◯ Yes ◯ No	Appointment Reminders: ◯ Text ◯ Voice	Social Security #: Date of Birth:

PARENT / GUARDIAN #2 ☐ Check here if this is the patient's guarantor (person responsible for charges not covered by insurance).

Last Name:		First Name:	MI:
Address:			
City/State/Zip:		Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:	Email Address:

Preferred Contact: ◯ Home Phone ◯ Mobile Phone ◯ Work Phone ◯ MAIL ONLY	OK to leave a message regarding your medical care on preferred phone? ◯ Yes ◯ No	Appointment Reminders: ◯ Text ◯ Voice	Social Security #: Date of Birth:

Revised 11/9/2017

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Patient Last Name:
Patient First Name:
Date of Birth:

Pediatrician Information

Pediatrician:	Phone:
Address:	

Insurance Information

Is this visit work related? ◯ Yes ◯ No	Authorization Number:

Primary Health Insurance		**Secondary Health Insurance**	
Insurance Name:		Insurance Name:	
Policy #	Group #	Policy #	Group #
Policy Holder's Name:		Policy Holder's Name:	
Policy Holder's Date of Birth:	Policy Holder's Social Security #:	Policy Holder's Date of Birth:	Policy Holder's Social Security #:
Policy Holder's Employer:	Relationship to Patient:	Policy Holder's Employer:	Relationship to Patient:

AUTHORIZATION and RELEASE OF INFORMATION

Initial:

_____ I am giving University Surgical Associates permission to ask for third party payor/Medicare payments for my medical care. I understand that third party payor/Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to third party payor/Medicare and the companies that handle third party payor/Medicare payment requests. I understand that the CENTERS FOR MEDICARE/MEDICAID SERVICES (CMS) is the government Medicare agency. I request that payment of authorized third party payor/Medicare benefit be made either to me or on my behalf for any services furnished me by USA, including physician services. I authorize any holder of medical or other information about me to release to the CMS and its agents any information needed to determine these benefits or benefits for related services.

_____ I understand that University Surgical Associates may obtain my prescription history from my pharmacy, other healthcare exchanges as well as querying the state prescription drug monitoring program.

_____ University Surgical Associates patient portal is a secure, confidential, HIPAA compliant communication tool. It is an optional service and you may enroll at any time. The portal is designed to enhance patient-physician communication. Access to this secure patient portal is an optional service. I may suspend or terminate it at any time for any reason. I acknowledge and fully understand the risks associated with online communication. I acknowledge that using the portal is voluntary and will not impact the quality of care I receive. I agree to adhere to the policies set forth in this agreement. I understand this consent will expire in 12 months and I will be required to sign and update my form. I will notify the office if there is any change in my email address or if I feel my password has been breached. I agree not to hold University Surgical Associates liable for infractions beyond its control. By signing below, i give permission to University Surgical Associates to enroll me in the patient portal.

_____ I have received University Surgical Associates' Notice of Privacy Practices.

Patient Signature (or guarantor if under 18):	**Date:**

Permission to Disclose Medical Information

I hereby authorize University Surgical Associates office to speak to the following people regarding my medical condition:

Name:	Relationship:
Name:	Relationship:

I understand I may revoke this permission at any time by informing the physician's office in writing.

Patient Signature (or guarantor if under 18):	**Date:**