



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:





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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: _____ _____ _____	<p>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.</p> <p>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.</p> <p>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.</p> <p>I have received University Surgical Associates' Notice of Privacy Practices.</p>

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