Crozer-Keystone Health Network
# Patient Registration Form

(for office use only: HIPAA)

Privacy Notice Date: ____________

**Today's Date:**

## Patient Information

**Social Security #:**

**Patient Name:** (last, first, middle) (maiden)

**Patient Address:**

| **City** | **State** | **Zip Code** |
|---|---|---|

**Home Phone:** ( )

**Cell Phone:** ( )

**Employer:**

**Employer Address:**

| **City** | **State** | **Zip Code** |
|---|---|---|

**Work Phone:** ( )

**Occupation:** ☐ Full Time ☐ Part Time

## Primary Insurance Information

**Insurance Company Name:**

**Address:**

| **Policy Number:** | **Group Number:** |
|---|---|
| **Policy Holder Name:** | **Date of Birth:** |

**Policy Holder Social Security #:**

**Relationship of Patient to Policy Holder:**

**Employer of Policy Holder:** ☐ Full Time ☐ Part Time

**Address:**

| **City** | **State** | **Zip Code** |
|---|---|---|

**Telephone #:** ( )

## Additional Information

☐ Person responsible for bills (if other than patient) ☐ Related Party

| **Name:** | **Date of Birth:** |
|---|---|

**Address:**

**Relationship to Patient:**
☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Child
☐ Life Partner ☐ Other Family Member

## Referring Physician (if not primary care physician)

**Name:**

**Address:**

| **City** | **State** | **Zip Code** |
|---|---|---|

**Telephone #:** ( )

## Primary Care Physician (for Specialty Offices only)

**Name:**

**Address:**

| **City** | **State** | **Zip Code** |
|---|---|---|

**Telephone #:** ( )

## Patient Information

| **Gender:** ☐ Male ☐ Female | **Date of Birth:** | **Age:** |
|---|---|---|

**Marital Status:**
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

**Race:** (for medical purposes – optional)
☐ African American ☐ White ☐ Hispanic ☐ Asian ☐ Other

**Email address:**

## Student Status Information

| **Student?** (18-26 yr. old) | ☐ Yes ☐ No | ☐ Full Time ☐ Part Time |
|---|---|---|

**Name of School:**

## Emergency Contact

**Name:**

**Relationship:**

**Telephone #:** ( )

## Secondary Insurance Information

**Insurance Company Name:**

**Address:**

| **Policy Number:** | **Group Number:** |
|---|---|
| **Policy Holder Name:** | **Date of Birth:** |

**Policy Holder Social Security #:**

**Relationship of Patient to Policy Holder:**

**Employer of Policy Holder:** ☐ Full Time ☐ Part Time

**Address:**

| **City** | **State** | **Zip Code** |
|---|---|---|

**Telephone #:** ( )

## Living Will

**Do you have a living will?** ☐ Yes ☐ No

**If no, would you like information?** ☐ Yes ☐ No

## Additional Information

**Are you allergic to latex?** ☐ Yes ☐ No

**May we call your work?** ☐ Yes ☐ No

**May we call your home and/or email you?** ☐ Yes ☐ No

**May we leave a message on your answering machine or email you to:**
- **Remind you of appointments?**
- **Ask you to call the office back?**
- **Inform you a prescription has been called in to your pharmacy?**

☐ Yes ☐ No

**May we leave a message with a member(s) of your household for the reasons above? (*We are not allowed to give others your medical information*).** ☐ Yes ☐ No

**If yes, please list the name(s):**

# CONSENT FOR OUTPATIENT SERVICES

I consent to examination, routine testing and medical treatment, which my doctor and/or other doctors who care for me believe is necessary. I understand medicine is not an exact science; no guarantees or promises have been made to me about my treatment. I accept that the services provided are given in the least restrictive setting and manner to meet my needs. If special procedures are needed, I will be asked by my doctor to give separate informed consent. I have the right to refuse any drugs, treatment, or procedures. I understand that neither the Hospital nor my doctor is responsible for my personal belongings during my care. I have read and understand this consent for care and my questions have been answered. My signature means I agree to the above. I can ask for a copy of this form.

_______________________________________ _____________________________________________

PATIENT/ AUTHORIZED PARTY DATE PRINT NAME DATE

_______________________________________ _____________________________________________

RELATIONSHIP TO PATIENT WITNESS NAME & INITIALS DATE

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**Consent for Photo Identification:**

I consent to having my picture used in my electronic medical record as a photo ID, to ensure the accuracy of my identity, also my safety.

________________________________________

Patient / Authorized party

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**ASSIGNMENT OF HEALTH INSURANCE BENEFITS AND AGREEMENT FOR FINANCIAL RESPONSIBILITY**

I authorize payment to my doctors and/or hospital of any health insurance benefits that are payable to me, including Medicare and/or Medicaid payments, Medigap payments, and/or payments under any Employer Self-Funded Medical Expense Reimbursement Plan as governed by the Employee Retirement Income Security Act (ERISA), and/or payments from private insurance companies. I certify that the information that I gave to my doctors and/or hospital to bill for payment is correct. I assign and transfer to Crozer-Keystone Health Network, my doctors and/or hospital or their agents the right to act in my place to bill and collect all payments that are payable to me under any private or government plan of health benefits and/or to sue any insurer or other responsible party to obtain these payments. These payments may not be more than the balance due my doctors and/or hospital and I understand that I have to pay my doctors and/or hospital for all charges not paid by my health insurance. This payment authorization, assignment of benefits and agreement for financial responsibility is also binding on my administrators, executors, heirs and successors.

I have read this assignment of benefits; I understand this assignment of benefits, and my questions have been answered.

________________________________________________ ________________________________________________

PATIENT/ AUTHORIZED PARTY DATE WITNESS NAME AND INITIALS DATE

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**AUTHORIZATION TO RELEASE INFORMATION FOR TREATMENT, PAYMENT OR OPERATIONS**

I understand the hospital and/or my doctor may use and disclose my health information for treatment, payment, or operations in accordance with the Crozer-Keystone Health System's Notice of Privacy Practices ("Privacy Notice") and I authorize the use and disclosure of my health information in accordance with the Privacy Notice.

I understand that if I am treated for HIV, drug and alcohol abuse, or mental health issues that this information will not be released without my specific written consent relating to these conditions. My signature below means that I have read this authorization and I understand this authorization to release my health information.

_______________________________________ _______________________________________

PATIENT/ AUTHORIZED PARTY DATE WITNESS NAME AND INITIALS DATE

*If consent from the patient is verbal because of the patient's physical inability to sign this consent form, please check this box and have a staff member sign as a witness above and a second witness sign here.

☐ __________________________________________

SECOND WITNESS' NAME DATE

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***NOTICE OF PRIVACY PRACTICES***

My signature below means that I have received a copy of the Crozer-Keystone Health System's Notice of Privacy Practices, which explains in more detail my rights to, and some of the uses and disclosures of my health information.

___________________________________________________________________

PATIENT or AUTHORIZED PARTY DATE

**PERMISSION NOTICE TO COMMUNICATE WITH MY CLINICIAN**

I am a patient of ________________________________.

My name is (please print) ______________________________________________

My birth date is (please print) ________________.

I give permission to:

Name______________________________ Relationship _____________________

Name______________________________ Relationship _____________________

Name______________________________ Relationship _____________________

Name______________________________ Relationship _____________________

to communicate with my clinician about <u>any and all</u> of my medical issues.

I will sign this paper and it will be put in my chart to allow ______________________________
(Clinician's Name)
and his/her staff my permission to speak about my medical condition at any time to the person/persons I named above.

I agree that, if I at any time decide to change this permission, I will notify the practice **<u>in writing</u>**.

________________________________________ ________________
Signature of Patient above Date

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