



# PATIENT REGISTRATION FORM

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Number \_\_\_\_\_

## PATIENT INFORMATION (Required data)

Please provide your Driver's License to the Receptionist to scan.

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Gender  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name \_\_\_\_\_

Middle \_\_\_\_\_

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

- Single  Married  Divorced
- Separated  Widowed  Domestic Partner

- Black  Caucasian  Hispanic
- Asian  American Indian  Pacific Islander
- Asian Pacific Amer.  Native Alaskan  Other Race

Patient Primary Language \_\_\_\_\_

- Employed  Unemployed  Retired  Student

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_

State/Zip \_\_\_\_\_

Employer Phone (\_\_\_\_\_) \_\_\_\_\_

Address (Bill to) \_\_\_\_\_

Apt. \_\_\_\_\_

City \_\_\_\_\_

State/Zip \_\_\_\_\_

Secondary Address \_\_\_\_\_

Apt. \_\_\_\_\_

City \_\_\_\_\_

State/Zip \_\_\_\_\_

E-mail \_\_\_\_\_

H  W  C Primary Phone (\_\_\_\_\_) \_\_\_\_\_

H  W  C Secondary Phone (\_\_\_\_\_) \_\_\_\_\_

Consent to leave phone message.  Yes  No

Preferred method of contact for appointment reminders:

- E-mail  Call  Text

### How did You Hear About Us?

- Event  Internet  Referring Provider
- Friend  Magazine/Newspaper  Television
- Family  Office Staff  Yellow Pages
- Hospital/ER  Radio  Other
- Insurance Company  Research Patient

## REFERRING PHYSICIAN

Referring Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## PHARMACY INFORMATION

Pharmacy Name \_\_\_\_\_ Pharmacy Phone (\_\_\_\_\_) \_\_\_\_\_

Pharmacy Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

I give consent to import my medication history from a trusted and secure external source. \_\_\_\_\_ Patient Initials

## PATIENT REPRESENTATIVE

Relationship to Patient \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

I authorize Digestive CARE to discuss with the above-named contact the following issues related to my care:

- All PHI (Protected Healthcare Information)  Emergency Contact Only  Medical Only  Financial Only \_\_\_\_\_ Patient Initials



I have an *Advanced Directive* or *Health Care Directive*.

Yes

No

**INSURANCE INFORMATION (Required Data)**

Please provide your Insurance card to the Receptionist to scan.

Please indicate your Plan type:  Individual/Exchange  Employer/Group  Employer Sponsored Medicare  
 Medicare  Medicare Advantage  Medicare Supplement  Medicaid Managed

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Plan Name \_\_\_\_\_ State Issued: \_\_\_\_\_

Insured (if other than Patient) \_\_\_\_\_ Relationship \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Insured's Employer \_\_\_\_\_ City/State \_\_\_\_\_ Employer Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Please indicate your Plan type:  Individual/Exchange  Employer/Group  Employer Sponsored Medicare  
 Medicare  Medicare Advantage  Medicare Supplement  Medicaid Managed

2nd Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Plan Name \_\_\_\_\_ State Issued: \_\_\_\_\_

Insured (if other than Patient) \_\_\_\_\_ Relationship \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Insured's Employer \_\_\_\_\_ City/State \_\_\_\_\_ Employer Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**ACKNOWLEDGEMENT OF PRIVACY NOTICE**

Your initials indicate that you were given and have read, understand and acknowledge *Mobile Med's* "Notice of Privacy Practices", which describes how we use and disclose your health information.

\_\_\_\_\_ Patient Initials Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT**

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment or examinations performed. I understand if I am not compliant with any recommendations made by my physician this could compromise my care. All the above will be discussed with me, by the attending provider prior to any proposed testing or any type of surgical procedures to be scheduled.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND PAY BENEFITS TO PHYSICIAN**

- 1. I hereby authorize *Mobile Med* to release or receive any information necessary to expedite insurance claims.
- 2. I hereby authorize *Mobile Med* to bill my insurance company directly for their services.
- 3. I hereby authorize payment directly to the Provider of any insurance benefits otherwise payable to me.
- 4. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to the *MobileMed* for which these fees are payable.

For further information, or to file a complaint with a State Ombudsman, please inquire with one of our staff members.

I certify that I understand and accept the contents of this form.

**SIGNATURE (Patient or Authorized Representative)** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRINTED NAME (Authorized Representative)** \_\_\_\_\_