

## PATIENT REGISTRATION FORM

### PATIENT INFORMATION

(Title) \_\_\_\_\_ Patient Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_  
mm dd yy

E-Mail Address: \_\_\_\_\_

Sex Assigned at Birth:  Female  Male  Hermaphrodite

Current Gender identity:  Female  Male  Transgender  Decline to Answer

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Other: \_\_\_\_\_

Race:  White  Black or African American  Asian  Pacific Islander  American Indian

Preferred Language:  English  Spanish  Other: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed  Partner  Domestic Partner

Employment Status (*select all that apply*):  Full-Time Employee  Part-Time Employee  
 Not Employed  Self-Employed  Retired  Active Military

Student Status:  Full-Time Student  Part-Time Student  Not a Student

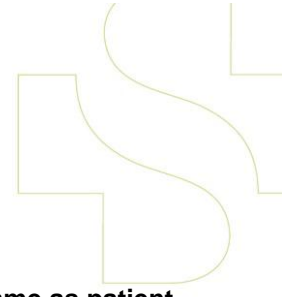
Additional Info:  Seasonal Resident  Migrant (Traveling)  Public Housing  Veteran

Emergency Contact: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Do you have a:  Living will  Advanced Directives  DNR  
 Power of Attorney  None  Refuse

Legal Guardian/Proxy or Caregiver: \_\_\_\_\_ Contact Phone: ( ) \_\_\_\_\_



### RESPONSIBLE PARTY INFORMATION

Responsible Party:  Self  Guarantor  **Check here if information is same as patient**

Responsible Party Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Guarantor SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Guarantor Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy

Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION

(Provide your insurance card to the front desk at check-in)

Insurance Company: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Patient Relationship to Insured: \_\_\_\_\_

Subscriber ID (Policy Number): \_\_\_\_\_ Group ID: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Patient Relationship to Insured: \_\_\_\_\_

Subscriber ID (Policy Number): \_\_\_\_\_ Group ID: \_\_\_\_\_

### CONSENT TO TREATMENT

I am a patient of CliniSanitas. By signing this form, I give my consent to be treated by the doctors of this practice.

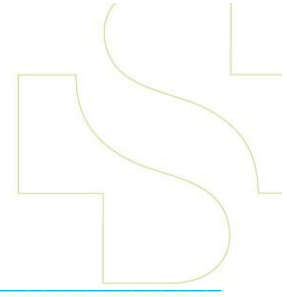
I understand treatment and services may include:

- Lab tests
- Routine exams
- Screening tests (tests that can find an illness early, before a person shows signs of having the disease)
- Diagnostic tests (tests that shows if a person has a certain illness or health problem)

I understand that no promises have been made to me about the results of any treatment or services.

I acknowledge that I have read and understood each of the above provisions appearing on this page. I have also had the opportunity to ask any questions, and by my signature, I consent and agree to such provisions individually and collectively. A copy may be used in lieu of the original.

Patient or Responsible Person Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy



**PHARMACY INFORMATION**

Pharmacy Name: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_ (Patient initials) **Pharmacy Consent.** I give the CliniSanitas authorization to obtain my prescription records from participating pharmacies.

**DISCLOSURE TO FRIENDS AND/OR FAMILY MEMBERS**

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below.

Name	Relationship	Phone Number
1.		
2.		
3.		

**PRIOR HEALTHCARE INFORMATION**

Provide name, contact information, and specialty of other health care professionals involved in the patient's care:

Name/Facility	Phone Number	Specialty
1.		
2.		
3.		

**CONSENT TO EMAIL OR PHONE FOR HEALTHCARE COMMUNICATIONS**

**Patients in our practice may be contacted via email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.**

If at any time I provide an email at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email from the practice.

May we contact you via email?    Yes    No    May we leave a voice messages?    Yes    No



## PATIENT HIPAA ACKNOWLEDGEMENT

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy

\_\_\_\_ (Patient initials) **Notice of Privacy Practice.** I acknowledge that I have received the practice's Notice of Privacy Practice, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the office if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

\_\_\_\_ (Patient initials) **Release of Information.** I hereby permit the practice and the physicians or other health professionals involved in my care to release healthcare information for the purposes of treatment, payment, or healthcare operations, or as allowed by law.

\_\_\_\_ (patient initials) **Medical Students.** CliniSanitas is proud to be an Academic Center for Florida International University Medical Students. With your consent, as part of the program, a student may be invited to speak to you about your visit and/or overall health before you are seen by your physician. Critical to the experience is the awareness and education of the importance of patient's privacy and confidentiality. As a result, all students participating in this program will have completed HIPAA compliance training, signed an agreement to adhere to the CliniSanitas Code of Conduct, and will have signed an agreement of confidentiality, prior to commencing, as to ensure that your patient rights are protected.

Patient or Responsible Person Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy

