CliniSanitas Medical Center

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: ( ) _____

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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

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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

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PATIENT HIPAA ACKNOWLEDEMENT

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