PATIENT REGISTRATION FORM

Infectious Diseases Associates, P.C.

Please give your insurance card(s) and government issued photo ID to front desk

DEMOGRAPHIC INFORMATION:

Patient Name (Last, First, MI): _____ DOB: _____

Address: _____ City, State, Zip: _____

Social Security #: ___-__-____

Home Phone: (___)___-____ Cell Phone: (___)___-____ Email Address: _____

Marital Status: Single / Married / Separated / Divorced / Widowed

Race: _____ Ethnicity: _____ Language: _____

EMPLOYER INFORMATION:

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

MEDICAL PROVIDER INFORMATION:

Primary Care Physician: _____

Address: _____ Telephone Number: _____

Referring Physician (if different than PCP): _____

Address: _____ Telephone Number: _____

PHARMACY INFORMATION:

Name of Pharmacy: _____

Address: _____ Telephone Number: _____

CONSENT TO OBTAIN PHARMACY INFORMATION ELECTRONICALLY:

I hereby consent to allow Infectious Diseases Associates, P.C. to obtain my pharmacy information, including medications, dosages, and prescriptions filled from participating pharmacies. This helps to reduce medication error while providing your physician with your most up-to-date medication profile.

Patient and/or guardian signature: _____ Date: _____

Patient Name: _____ DOB: _____

MEDICAL HISTORY

Please list any medical issues and date of onset: _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____.

Please list any surgeries, including dates: _____, _____, _____, _____, _____, _____, _____, _____.

Please list all allergies: _____, _____, _____, _____, _____, _____, _____, _____.

Please list all medications both prescription and over-the-counter medications, including strength and directions, as well any vitamins or supplements: _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____.

SMOKING STATUS:

CURRENT / FORMER quit date_____ / NEVER

FAMILY HISTORY:

Mother: _____ Father: _____

Grandmother (maternal) _____ Grandmother (paternal) _____

Grandfather (maternal)_____ Grandfather (paternal) _____

Sibling1_____ Sibling2 _____

Additional family history: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____ Address: _____

Telephone Number: _____ Relationship to Patient: _____

I authorize Infectious Diseases Assoc., P.C. to speak with or release information to the following people:

Name _____ Phone: _____ Relationship: _____

Name _____ Phone: _____ Relationship: _____

Name _____ Phone: _____ Relationship: _____

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I (or designated guardian) authorize Infectious Diseases Associates, P.C. (IDA, PC) to provide treatment and release medication information to my insurance as necessary for payment of physician claims. I (or designated guardian) hereby authorize payment directly to IDA, PC of the benefits otherwise payable to me but not to exceed regular charges for physician claims. I (or designated guardian) understand that I am financially responsible to IDA, PC for charges not covered by my insurance.

_____ _____

PATIENT AND/OR GUARDIAN SIGNATURE DATE

AUTHORIZATION FOR RELEASE OF INFORMATION

I (or designated guardian) authorize IDC, PC to supply to another physician involved in my medical care a copy of necessary medical records and/or test results requested by the physician but ordered by my primary care physician. I understand this is for the release of medical information only. If I am a managed care subscribed, I (or designated guardian) authorize IDA, PC to allow my Managed Care Organization access to my chart for quality review purposes.

_____ _____

PATIENT AND/OR GUARDIAN SIGNATURE DATE

CONSENT TO SEND APPOINTMENT REMINDERS

I (or designated guardian) hereby consent to allow IDA, PC use of medical information for the purpose of sending appointment reminders, unless and until revoked by me in writing.

_____ _____

PATIENT AND/OR GUARDIAN SIGNATURE DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I. I (or designated guardian) acknowledge receipt of notice by signature:

_____ _____

PATIENT AND/OR GUARDIAN SIGNATURE DATE

II. Unable to obtain signature due to:
   a. Patient Refused
   b. Patient incapable of signing (please explain)_____
   c. Other _____

_____ _____

OFFICE STAFF SIGNATURE DATE

NOTE: We may also disclose PHI to your other healthcare providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain healthcare operations, such as quality assessment and improvement activities, reviewing the quality and competence of healthcare professionals, or for healthcare fraud and abuse detection or compliance. We may use your PHI for purposes of calling your home or alternate locations and leaving a message or voicemail or in person in person to any items that assist IDA, PC in carrying out TPO (Treatment, Payment, and Healthcare Operations), such as appointment reminds, insurance items, and any calls pertaining to your clinical care, including laboratory results among others, unless or until revoked by you in writing. We may mail to your home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient's statements, unless or until revoked by your in writing.

Patient Name: _____ DOB: _____

MEDICARE PATIENTS (MUST COMPLETE THE NEXT TWO SECTIONS)

MEDICARE BENEFITS Patient's certification, authorization to release information and payment request: I certify that the information given by me in applying for payment until Title XVII of the Social Security Act is correct. I authorize any holder or medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for physician claims and other related medical claims. I request that payment of claims be made on my behalf for authorized benefits under my health insurance. I hereby authorize payment directly to IDA, PC for insurance benefits otherwise payable to me. Payments are not to exceed the balance due of the practice's regular charges for these claims. I understand that I am financially responsible to IDA, PC for charges not covered by this authorization. I understand that IDA, PC will bill HCDA using the term "signature on file" and am aware that my signature as written below constitutes that "signature on file".

_____ _____

PATIENT AND/OR GUARDIAN SIGNATURE DATE

MEDIGAP BENEFITS I hereby give IDA, PC permission to ask for Medigap payments for my medical care. I understand that my Megigap Insurer needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to my Medigap Insurer. I request that payment of authorized Medigap benefits be made to Infetious Diseases Associates, P.C. on my behalf for nay services furnished tome by IDA, PC. I authorize any holder of medical information about me to release Medigap Insurer any information needed to determine these benefits of the benefits payable for related services.

_____ _____

PATIENT AND/OR GUARDIAN SIGNATURE DATE