



# Patient Registration Form

<b>Office Use Only</b> <input type="checkbox"/> INS/ID cards on file <input type="checkbox"/> Pt Registration complete  
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\_\_\_\_\_  
**First, Middle, Last Name** Preferred Name Maiden Name

\_\_\_\_\_  
 Address City, State, Zip Code Gender:  Male  Female

\_\_\_\_\_  
 Date of Birth Social Security Number Marital Status:  Single  Married  Divorced  Widowed

\_\_\_\_\_  
 Home Phone: Cell Phone: Email Address

<input type="checkbox"/> OK to email <input type="checkbox"/> OK to text for appointment reminders
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\_\_\_\_\_  
 Employer Work Phone:

\_\_\_\_\_  
**Preferred Pharmacy (name)** Pharmacy Location/Address

\_\_\_\_\_  
**Family Physician (PCP)** City/State **Referring Physician** City/State



**Emergency Contact Information:**

\_\_\_\_\_  
 Name Phone Number Relationship to Patient

If patient is a minor, please list person responsible for payment:

\_\_\_\_\_  
 Name/Relationship to Patient Address Phone Number



**Primary Insurance Information**

\_\_\_\_\_  
 Insurance Company ID/Policy#

\_\_\_\_\_  
 Subscriber Name/Relationship to Patient Subscriber D.O.B Subscriber SS#

**Secondary Insurance Information**

\_\_\_\_\_  
 Insurance Company ID/Policy#

\_\_\_\_\_  
 Subscriber Name/Relationship to Patient Subscriber D.O.B Subscriber SS#

I hereby authorize my insurance benefits to be paid directly to Reconstructive & Aesthetic Surgeons, Inc. and authorize the release of my medical information to process my insurance claims. I understand I am financially responsible for all services rendered. I agree to pay reasonable attorney fees and all costs of collection, in the event of default.	
<b>Signed:</b> _____	<b>Date:</b> _____
<b>Signed:</b> _____	<b>Date:</b> _____
<b>Signed:</b> _____	<b>Date:</b> _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

In order to facilitate prompt notification of appointments, surgery dates and biopsy or lab results we need your permission to leave a detailed message on your home, cell or other phone number provided.

**I consent to be contacted in the following manner (check all that apply):**

Home     Cell     Work     On the answering machine     With anyone who answers the phone

OK to MAIL to Home     DO NOT MAIL TO HOME     OK to Mail to Other: \_\_\_\_\_

I permit the Practice to discuss my PHI with, and to disclose my PHI to, the following individuals:

<b>Name</b>	<b>Relationship</b>	<b>Home Phone</b>	<b>Cell Phone</b>



All Patients have the right to participate in their own health care decisions and to make "Advance Directives" or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the Patients expressed wishes when the Patient is unable to make decisions or unable to communicate decisions.

Please initial below as applicable:

- \_\_\_\_\_ Yes, I have an "Advance Directive", Living Will or Health Care Power of Attorney
- \_\_\_\_\_ No, I do not have an "Advance Directive", Living Will or Health Care Power of Attorney
- \_\_\_\_\_ I would like to have information on "Advance Directives".

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for protected health information (PHI) to the minimum necessary to accomplish the intended purposes. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided if completed properly, will constitute an adequate record.

**NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

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