Ascension Medical Group Genesys
Patient **R**egistration **F**orm

Today's Date: / / Primary Care Physician:

PATIENT INFORMATION

Legal name as printed on Driver's License: (Please print)

Last: First: Middle:

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Alias / Nickname:

Birth date: / / Age: Sex: ☐ M ☐ F Marital status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Do you have an Advance Directive? ☐ Yes ☐ No Authorized Power of Attorney ☐ Yes ☐ No

Race: ☐ Asian ☐ Black ☐ White ☐ Hispanic/Latino ☐ Native American ☐ Pacific Isle ☐ Other ☐ Refused

Language: ☐ English ☐ Other: Pharmacy: Location:

Are you a Veteran or the family member of a Veteran: ☐ Yes ☐ No

Home phone #: ( ) - Cell phone #: ( ) - SSN: - -

Street address: Apt #:

City: State: ZIP Code:

Email address:

Occupation: Employer: Emp phone #: ( ) -

Was this an injury: ☐ Yes ☐ No If yes, which: ☐ Auto ☐ Worker's Comp ☐ Other:

IF YOU ANSWERED YES PLEASE COMPLETE THE WORKER'S COMPENSATION OR AUTO ACCIDENT PATIENT REGISTRATION FORM

HEALTH INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist

Primary Insurance:

Policyholder's Name (as listed on insurance card): Policyholder's Date of Birth: / / Policyholder's SSN: - -

Insurance ID#: Group#

Policyholder's Employer:

Patient's relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance (if applicable):		
Policyholder's Name (as listed on insurance card):	Policyholder's Date of Birth: : / /	Policyholder's SSN: - -
Policyholder's Employer:		
Insurance ID#:		Group#:
Patient's relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Responsible party name:		

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address):	
Relationship to patient:	Phone #: ( ) -

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.
(You may list spouse, children, relatives, etc.)

Name(s): Relationship to patient:

PRIVACY STATEMENT:

We protect our patient's information and the records that we have about their health and the services received in our office. We must have your written, signed consent in order to disclose your health information for the purposes of your treatment, the payment of your bills, appointment reminders etc. I have received a copy of the Privacy Notice. (HIPAA - 164.520) Effective 04/14/2003. I f we refer our patients to another provider or specialist, we may need to share your medical information with them. Your privacy is protected as only minimum information is shared.

Signature: _____ Date: _____

Please provide a preferred telephone number where you want to receive calls. : ( ) -

May we leave a confidential message about your care on your answering machine / voice mail? ☐ Yes ☐ No

- Financial Responsibility: The above information is true to the best of my knowledge. I authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign the doctor all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by insurance and that I will pay any co-pays on the date of service unless other arrangements are made.

Responsible Party Signature: _____ Date: _____

- Medicare Authorization: I request that payment of authorized Medicare benefits be made to the Ascension Medical Group Genesys on my behalf. I authorize the holder of my medical information to release to the HCFA and their agents any information needed to determine these benefits for related services. I understand that HCFA is the government Medicare agency.

Medicare Beneficiary Signature: _____Medicare #:_____ Date: _____