

PATIENT REGISTRATION FORM

PATIENT'S FULL LEGAL NAME: _____		NICK NAME: _____	
(PLEASE PRINT)		(IF ANY)	
ADDRESS 1: _____	HOME PHONE: (____) _____		
ADDRESS 2: _____	WORK PHONE: (____) _____	EXT: _____	
CITY: _____ ST: _____ ZIP: _____	CELL PHONE: (____) _____		
DATE OF BIRTH: ____/____/____	AGE: _____	PATIENT'S SS#: ____/____/____	
SEX: ___M ___F	MARITAL STATUS: ___M ___D ___W ___S	E-MAIL ADDRESS: _____	
EMERGENCY CONTACT PERSON _____		RELATIONSHIP: _____	
HOME OR WORK PHONE#: (____) _____		EMERGENCY CONTACT CELL NUMBER: (____) _____	
(NOT YOUR OWN HOME PHONE#)			

INFORMATION ON FAMILY MEMBER CARRYING THE INSURANCE:

FULL LEGAL NAME: _____		RELATIONSHIP TO PATIENT: _____	
ADDRESS 1: _____	CITY: _____	ST: _____	ZIP: _____
DATE OF BIRTH: ____/____/____	YOUR (RESPONSIBLE PARTY) SS#: ____/____/____		
HOME PHONE: (____) _____	WORK PHONE: (____) _____	EXT: _____	
CELL PHONE: (____) _____	EMPLOYER NAME: _____		

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Central Ohio Primary Care – Family Practice Center of Westerville, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care and to conduct health care operations. I understand that diagnosis and treatment of me by Family Practice Center of Westerville, may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Family Practice Center of Westerville is not required to agree to the restrictions that I may request. However, if Family Practice Center of Westerville agrees to a restriction that I request, the restriction is binding on Central Ohio Primary Care – Family Practice Center of Westerville.

I have the right to revoke this consent, in writing, at any time, except to the extent that Central Ohio Primary Care – Family Practice Center of Westerville has taken action in reliance on this consent.

My "protected health information" means health information, including any demographic information collected from me or received by my physician, another health care provider, my employer or health care clearinghouse. This protected health information related to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to have provided to me and review Central Ohio Primary Care – Family Practice Center of Westerville, our Notice of Privacy Practices before signing this document. The Notice of Privacy Practices is also posted for review in the reception area. This notice describes the types of uses and disclosures of protected health information that will occur in my treatment, payment of my bills or in the practice of health care operations of the practice.

Central Ohio Primary Care – Family Practice Center of Westerville reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by call the office and requesting that a revised copy be sent to me or asking for one at the time of my next appointment.

Consent for release of information by phone/voice mail – Do we have your permission to:

Call your home? ___Y ___N Leave general information on home voice mail? ___Y ___N Call your cell phone ___Y ___N
 Call you at work? ___Y ___N Leave general information on your work voice mail? ___Y ___N

Signature of patient or personal representative _____	Description of personal representative authority: Self, Parent, POA _____	Date of this authorization _____
DATE & INITIALS OF STAFF VERIFYING DEMOGRAPHICS: _____		