Patient Registration

Patient's Name ____ **DOB** ____-____-____ **Age** _______ **Gender:** M / F
(First) (MI) (Last)

Address: ____
(Street) (City) (State) (Zip) (County)

Race: [ ] American Indian [ ] Asian [ ] African American [ ] Caucasian [ ] Native Hawaiian or Pacific Islander
[ ] Other [ ] Patient Declined

Ethnicity: [ ] Non-Hispanic [ ] Hispanic [ ] Patient Declined **Language:** [ ] English [ ] Spanish [ ] Other

Home Phone (_____) _____________ **Work Phone** (_____) _____________ **Cell Phone** (_____) ___________________________

Patient's SS# ______-____-______ **Financial Responsibility**: [ ] Patient [ ] Other _______________________________________

Is patient currently working? [ ] Yes [ ] No **Patient's Employer** ____

Employer's Address ____
(Street) (City) (State) (Zip)

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated Spouse's Name ___________________________

Person we may contact in case of emergency ______________________________________ **Relationship**_____________________

Phone (_____) ______________ Address ____
(Street) (City) (State) (Zip)

INSURANCE INFORMATION We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance cards with you to the front desk when you have completed this form.

PRIMARY INSURANCE COVERAGE

Insurance Company ___________________________ **Address**____

Policy Holder's Name _____________________________________ **Policy Holder's Gender:** [ ] Male [ ] Female

Policy Holder's DOB _____-_____-_____ **Policy Holder's SS#**______-____-______ **Policy Holder's Employer** __________________

Subscriber ID # ___________________ **Group #** __________________

Patient's Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other ____

SECONDARY INSURANCE COVERAGE

Insurance Company ___________________________ **Address**____

Policy Holder's Name _____________________________________ **Policy Holder's Gender:** **[ ] Male [ ] Female**

Policy Holder's DOB _____-_____-_____ **Policy Holder's SS#**______-____-______ **Policy Holder's Employer** ___________________

Subscriber ID # ___________________ **Group #** __________________

Patient's Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other ____

How Did You Hear About Us?____

Patient Name ____ **Date of Birth** ______________

Preferred Contact Method: [ ] Phone [ ] Mail [ ] Email ______________________@______________________

Financial Agreements and Authorization for Treatment: I hereby authorize Harnett Health and its physicians and other providers and staff to furnish and perform on me or the patient stated above ("Patient") such medical care, examination, and treatment as may be ordered by a Harnett Health provider. I hereby authorize direct payment to Harnett Health of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by Harnett Health to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to Harnett Health for charges not covered by this agreement, and I hereby guarantee payment to Harnett Health on demand for all such charges. I understand that all co-pays and self pay monies are collected up front before services are rendered.

Signature ________________________________ Date ______________

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor

Authorization to Release Information: I hereby authorize Harnett Health to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and /or treatment to any insurance company, government agencies and their agents, and professional review organizations with which I or the Patient stated above may have insurance coverage or which may be assisting in payment of the medical care provided by Harnett Health to me or the Patient stated above. I also hereby authorize Harnett Health to release any medical information to any licensed physician, health care provider, or medical facility to which I or the Patient stated above may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

Signature ________________________________ Date ______________

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor

Receipt of Notice of Privacy Practices: I understand and have been provided with a Harnett Health' Notice of Privacy Practices, which provides a more complete description of how Patient health information may be used or disclosed. I understand that Harnett Health reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from any employee of Harnett Health.

Signature ________________________________ Date ______________

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor