Harnett Health

Patient Registration

Patient's Name _____ **Date of birth** _____-_____-_____ **Gender:** M / F
(First) (Middle) (Last)

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

Home Phone: (_____) -- _____ Disabilities: ___ hearing ____vision _____speech ____other
Preferred Language: [ ]English [ ]Spanish [ ]Other
Race: [ ]American Indian [ ]Asian [ ]African American [ ]Caucasian [ ]Native Hawaiian or Pacific Islander [ ]Other
Ethnicity: [ ] Non-Hispanic [ ]Hispanic [ ]Patient Declined
Religious Preference: [ ]Christianity [ ]Jehovah Witness [ ]Buddhism [ ]Islam [ ]Scientology [ ]Hindu [ ]Other

Email: _____ (for use with our patient portal—ask us)

Mother/Guardian: _____ Date of birth _____ SS#: _____

Home Phone (____) _____ **Cell Phone** (_____) _____

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

Employer: _____ Work Phone: _____

Father/Guardian: _____ Date of birth _____ SS#: _____

Home Phone (____) _____ **Cell Phone** (_____) _____

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

Employer: _____ Work Phone: _____

In case of emergency contact:_____Relationship_____ Phone: _____

INSURANCE INFORMATION : We cannot file your insurance without complete information and a copy of your insurance card(s).
Please bring your insurance cards with you to the front desk when you have completed this form and also to each visit.

PRIMARY INSURANCE

Insurance Name_____ Policy Holder's Name _____

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

Subscriber ID # _____ Group # _____

SECONDARY INSURANCE

Insurance Name _____ **Policy Holder's Name** _____

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

Subscriber ID # _____ Group # _____

Patient Name _____

Financial Agreements and Authorization for Treatment: I hereby authorize Harnett Health physician practices and its providers and such assistants as a provider may designate to furnish and perform such medical care, examination, and treatment as may be ordered by a Harnett Health physician practices provider in his or her medical judgment and such medical care, examination, or treatment as is reasonable. I hereby authorize direct payment to Harnett Health physician practices 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 physician practices 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 physician practices for charges not covered by this agreement, and I hereby guarantee payment to Harnett Health physician practices on demand for all such charges. I understand that all co-pays and self pay monies are collected up front before services are rendered.

Parent / Guardian Signature _____ _____ Date _____

Authorization to Release Information: I hereby authorize Harnett Health physician practices 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 physician practices to me or the Patient stated above. I also hereby authorize Harnett Health physician practices 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 or to a school nurse when requested. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

Parent / Guardian Signature _____ Date _____

Receipt of Notice of Privacy Practices: I understand and have been provided with a Harnett Health physician practices 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 physician practices 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 physician practices.

Parent / Guardian Signature _____ Date _____