Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (☐ cell or ☐ work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M F Social Security Number: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient's Employer: _____ Employment Status: [ ] Full time [ ] Part time [ ] Unemployed
[ ] Retired [ ] Student [ ] Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION- Please provide a copy of all insurance cards as well as a photo ID

Primary Insurance: _____ Secondary Insurance: _____

Patient is Policy Holder: Y N Patient is Policy Holder: Y N

INSURED INFORMATION - **IF THE SUBSCRIBER IS NOT THE PATIENT, THE SECTION BELOW MUST BE FILLED OUT**

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): _____ Relationship to Patient: _____

Patient / Parent or Guardian Signature: _____ Date: _____

Embassy Surgery Center
HEALTH HISTORY

Personal Information Date: _____

Patient Name: _____ Birth Date: _____/_____/_____ Age: ____

Occupation _____ Marital Status: _____ Name of Partner/Spouse: _____

Race: [ ] Asian [ ] Black or African American [ ] Native American [ ] White / Caucasian

[ ] Hispanic [ ] Other: _____

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: _____

Number of children: _____ Children's Names/Ages: _____

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor:

_____

_____

_____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Do you have a **Latex Allergy** (list type of reaction): _____

Any **Allergies** to Medication or Food (list reactions): _____

Preferred **Pharmacy**: _____

Date of Last Complete Physical Exam: _____ Date of Last Blood Work: _____

Date of Last Colonoscopy: _____ Date of Last Tetanus Shot: _____

For Females: Date of Last Menstrual Period: _____ Date of Last Pap Smear: _____

History of Abnormal Pap (list date/s)? _____ Date of Last: Mammogram: _____ DEXA: _____

Number of Pregnancies: _____ Miscarriages: _____ Terminations: _____ Living Children: _____

Method/s of Contraception: _____

If **YOU** or a **FAMILY MEMBER** has had any of the following, please circle and indicate which family member when applicable:

ADD/ADHD	Type 1 or 2 Diabetes	Respiratory Disease
Anemia	Fractures	Skin Disease
Allergies/Hay Fever	Gynecological Disease	Stomach/Colon Disease
Asthma	High Blood Pressure	Stroke
Arthritis	High Cholesterol	Seizure Disorder
Anxiety/Depression	Heart Attack	Thyroid Disorder
Alcoholism	Kidney Disease	Sexually Transmitted Disease
Blood Clots	Liver Disease	Other:
Cancer, Type/s	Neurological Disease	_____
_____	Osteopenia/Osteoporosis	
	_____	

Please list any **SURGERIES** you have had and include the month/year:

_____

_

_____

_

_____

_

_____ **Social Information**

Tobacco Use: Do you smoke? _____ If so, how many cigarettes/cigars per day: _____ No. of years smoking: _____ Do you chew tobacco? _____ Have you thought about quitting? _____ Have you quit before? ____ How long? ____

Alcohol Use: Do you drink alcohol? ____ If so, what type? _____ How many in 1 week? _____

Drug Use: Any history of illegal drug use? _____ If so, what type/s? _____ When? _____

Do you **exercise**? _____ What activities do you do, and how often in 1 week? _____

_____

Are you on any special **diet**? _____ If so, what? _____

Do you consume any **caffeinated** products? _____ If so, what and how much per day? _____

Have you recently noticed an increase in sadness or gloominess? _____

Have you lost interest in enjoyable activities? _____

Do you have a living will? _____ If yes, please provide us a copy.

Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Embassy Surgery Center and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Embassy Surgery Center, the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Embassy Surgery Center for this admission or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only** - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Ambulatory Surgery Center and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. **Residents, Interns or Medical Students-** I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Embassy Surgery Center's education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Embassy Surgery Center. *I understand and agree this document will remain in effect for all future outpatient surgery visits to Embassy Surgery Center, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____

Patient Name_____