

**PATIENT REGISTRATION FORM**

Patient Name: (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_ (Last) \_\_\_\_\_

Street Address: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Include in Newsletter Mailing:  Yes  No

Patient's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Emergency Contact Information:**

- Home
- Cell
- Work

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**How did you hear about us?**

Friend/Family: \_\_\_\_\_ Phonebook: \_\_\_\_\_ Website/Internet: \_\_\_\_\_ Bella Via: \_\_\_\_\_ Word of Mouth: \_\_\_\_\_ Other: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Address: \_\_\_\_\_

Family Physician (PCP): \_\_\_\_\_ Address: \_\_\_\_\_

**Responsible Party Information (If other than patient):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Is your visit today being filed as a Workers Compensation Claim?  Yes  No

**Primary Insurance Information**

Insurance Company: \_\_\_\_\_ ID/Policy #: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Cardholder Date of Birth: \_\_\_\_\_ Cardholder Social Security #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Group #: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_

**Secondary Insurance Information**

Insurance Company: \_\_\_\_\_ ID/Policy #: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Cardholder Date of Birth: \_\_\_\_\_ Cardholder Social Security #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Group #: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_

I hereby authorize my insurance benefits to be paid directly to Reconstructive & Aesthetic Surgeons, Inc. and authorize the release of my medical information to process my insurance claims. I understand I am financially responsible for all services rendered. I agree to pay reasonable attorney fees and all costs of collection, in the event of default.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE COMPLETE REVERSE SIDE**



In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

**Oral Communication:**

**Home Phone:**

- DO NOT CALL
- Detailed Message \*
- Call Back Number Only \*\*

**Cell Phone:**

- DO NOT CALL
- Detailed Message \*
- Call Back Number Only \*\*

**Work Phone:**

- DO NOT CALL
- Detailed Message \*
- Call Back Number Only \*\*

\* A **Detailed Message** would include where we are calling from (physician's name), office phone number and a **brief** message as to the reason for the call.

\*\* A **Call Back Number Only** would include **just the office phone number and no other identifying information** (such as the physician's name or brief message).

**Written Communication:**

- DO NOT MAIL TO HOME OR WORK
- OK to mail to my Home Address
- OK to mail to my Work Address
- Other: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for protected health information (PHI) to the minimum necessary to accomplish the intended purposes. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided if completed properly, will constitute an adequate record.

**NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**