**PLYMOUTH GI**
**47 OBERY STREET PLYMOUTH, MA 02360**
**508-747-1560**

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# PATIENT REGISTRATION FORM

***Please tell us about yourself***

**NAME** (last)_____(first)_____(mi)____
**D.O.B.**____/_____/_____ MALE FEMALE MARITAL STATUS _____
**MAILING ADDRESS**_____
city_____state_____zip_____ **SS#** _____-_____-_____

**HOME PHONE#**_____ **CELL#**_____
**YOUR EMAIL ADDRESS**_____

**PRIMARY CARE PHYSICIAN**_____
**LOCAL PHARMACY**_____city_____

**INSURANCE with subscriber ID#** (Primary) _____
(Secondary) _____

*Recent government mandates require us to ask about race, ethnicity and a preferred language. This information is used to provide the best quality healthcare and is voluntary.*
Which of the following best describes your race? _____Asian _____Caucasion _____Black or African American
_____American Indian or Alaska Native _____Native Hawiian or Pacific Islander _____Patient Declined
Which of the following best describes your ethnicity? _____non Hispanic or Latino _____Hispanic or Latino _____Patient declined
What is your language preference? ____English _____French _____Portuguese _____Spanish _____Patient Declined

EMPLOYER_____ ADDRESS_____
PHONE NUMBER_____

***Emergency Contact Information-we will only contact this person in case of emergency only***
*This does not grant permission to obtain on your behalf, health & other information.*

IN CASE OF EMERGENCY, NOTIFY: _____ PHONE_____

ADDRESS_____RELATIONSHIP_____

8/18/2015

***Consent for release of information for treatment, payment and health care operations***

I authorize the above named practice to use and or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that, while this consent is voluntary, if I refuse to sign this consent, the practice can refuse to treat me.

I understand that I may revoke this consent this consent at any time by notifying the above named practice in writing, but if I revoke my consent, such revocation will not affect any actions that the practice took before receiving my revocation.

**SIGNATURE:**_____
**PRINT NAME:**_____
**TODAY'S DATE:**_____

***Guarantor of account***

I understand that I am responsible for account balances for services that are not covered by my insurance carrier. If my insurance does not cover medical services provided to me, I agree that I will be financially responsible for the payment of these non- covered services, co-pays, deductibles and coinsurances.

**SIGNATURE:**_____
**PRINT NAME:**_____
**TODAY'S DATE:**_____

***Privacy Practice Acknowledgement***

The Health Insurance Portability and Accountability Act (HIPAA) has entitled me to certain health information privacy rights. I have been provided an opportunity to review the Notice of Privacy Practices that more completely describes my protected health information.

**SIGNATURE:** _____
**PRINT NAME:** _____
**TODAY'S DATE:** _____