Reviewed by patient yearly (PLEASE SIGN and DATE- 1 LINE PER YEAR)

_____ _____ _____

CLARKSTON INTERNAL MEDICINE, P.C.
PATIENT REGISTRATION FORM

GOVERNMENT REGULATIONS REQUIRE ALL OF THIS INFORMATION TO BE PUT INTO YOUR ELECTRONIC MEDICAL RECORD. PLEASE FILL OUT THIS FORM IN ITS ENTIRETY.

Patient Name _____ Date of Birth_____

Address_____ Apt _____ City _____ Zip_____

SS#_____ Gender M F O Marital Status S M D W Other

Home ( )_____ Cell ( )_____ Work ( )_____

Email Address_____ would you like to be set up for our patient portal Y N

Employer (Patient or Parent)_____ Employer phone ( )_____

Spouse Name_____ Spouse Date of Birth_____

Emergency Contact (*other than in home*)_____

Phone ( )_____ Relationship_____

Do you have an Advance Directive? (Living will) Y N Authorized Power of Attorney? Y N

Race: Asian Black Caucasian Other_____ Ethnicity: Hispanic Non-Hispanic

Primary Language_____

INSURANCE INFORMATION (please present cards to front desk staff)

Insurance Carrier_____ Subscriber Name_____ DOB_____

Secondary _____ Subscriber Name_____ DOB_____

HIPAA STATEMENT: We protect our patients' information and the records that we have about their health and services received in our office. We must have a WRITTEN and SIGNED consent in order to disclose your health information for the purpose of your treatment, the payment of your bills, appointment reminders etc. I understand that I may revoke authorization or change those listed at any time in writing. Notice of Privacy Practice form is available upon request.

Signature_____ Date_____

PLEASE LIST ANY FAMILY MEMBERS OR PERSONS, IF ANY, WHOM WE MAY INFORM ABOUT GENERAL CONDITION, DIAGNOSIS, MEDICATION REFILLS, AND APPOINTMENTS (Separate from Emergency Contact)

_____ _____

_____ _____

Can we leave a confidential message on your answering machine or voice mail? Y N

***Financial Responsibility**: I authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by MY insurance and that I will pay any copays on the date of service unless other arrangements are made.

Responsible Party Signature_____ Date_____

***Medicare Authorization**: I request that payment of authorized Medicare benefits be made to Clarkston Internal Medicine, P.C. on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. I authorize any holder of PHI to release to CMS if needed to determine payable benefits to related services.

Responsible Party Signature_____ Date_____