PRIMARYHEALTH

PRIMARY HEALTHCARE ASSOCIATES
NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name Last	First	MI	Maiden Name/Also Known As (AKA)

Social Security #	Sex ___ Male ___ Female	Date of Birth	Marital Status ____M ____S ____D ____W

Street Address	Apt #	City	State	Zip	Spouse's Name

Cell Phone #	Home Phone #	E-Mail Address	Work Phone #

Preferred Method of Contact? ____ Cell Phone ____ Home Phone ____ Alternate Phone # _____

Do you have a Primary Care or Family Physician (PCP)? ____ YES _____ NO

Language:

___ English ___ Italian
___ Spanish ___ Korean
___ Polish ___ Portuguese
___ Chinese ___ Russian
___ German ___ Other

Ethnicity:

___ Hispanic/Latino
___ Not Hispanic/ Not Latino

Who is your Family or Primary Care Physician (PCP)?

PCP Name: _____
PCP City, State: _____
PCP Phone Number : _____

Race:

___American Indian/Alaska Native
___Asian ____Black/African American
___Native Hawaiian/Pacific Islander
___White

How were you referred to our office today?

___ My Physician/Doctor's Office (Drs Name) _____
City, State _____
___ Relative, Friend, Neighbor ___ Mailing/Postcard/Door Hanger/Letter
___ Inquicker/Care Connection ___ Walk In/Drive By ___ Hospital/ER
___ Ingalls/ISDS/MCX Employee ___ Flyer/Poster ___ Internet
___ Insurance Network ___ Urgent Aid (Which one? _____)
Other: _____

IN CASE OF AN EMERGENCY CONTACT:

Name Last	First	MI	Relationship

Home Phone # _____	Work Phone # _____
Cell Phone #	Alternate Phone #

INSURANCE INFORMATION

Primary Insurance Company Name _____

Secondary Insurance Company Name _____

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PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT: Name Last	First	MI	Sex ___Male ___Female
Street Address	Apt #	City State Zip	Relationship

Home Phone #	Work Phone #	Cell Phone #	Alternate #
Social Security #	Date of Birth		

PHARMACY INFORMATION

Do you use the Ingalls Pharmacy? Yes, I use the Ingalls Pharmacy in: _____ Harvey _____ Flossmoor _____ Tinley Park

No, my Pharmacy Name is: _____

Address, City, State, Zip: _____

Phone #: _____ Fax #: _____

CONSENT TO TREATMENT AND RELEASE OF INFORMATION

Unless otherwise directed below, if I am unavailable, the Physician may communicate normal test results via home telephone, voicemail or answering machine to the home phone numbers on this form, as long as the nature of the call is not disclosed.

In addition, my normal test results may be left on the following answering machine/voice mail. _____

In addition, my normal test results may be communicated to _____ Relationship _____

No, I want my test results only communicated personally to me. **Initials** _____

I authorize examination and medical treatment, verification of benefits and the release of information (including the diagnosis and medical records) to other physicians involved in my care, to my insurance company to facilitate billing and reimbursement, and for quality assurance purposes. I acknowledge that I have been offered and received or declined to receive a copy of the HIPAA Notice of Privacy Practices. I authorize benefits to be paid directly to the Physician and I understand that I am responsible for any unpaid balance under the terms of my insurance policy.

PRINT PATIENT OR LEGAL GUARDIAN NAME _____

PATIENT OR LEGAL GUARDIAN SIGNATURE _____ DATE _____

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