Patient Registration Form

Patient Information

Last Name:	First Name:	MI:
Address:		
City/State/Zip:		

Preferred Contact: Home Phone Mobile Phone Work Phone MAIL ONLY	OK to leave a message regarding your medical care on preferred phone? Yes No	Appointment Reminders: Text Voice	Date of Birth: Gender assigned at birth: Male Female

Home Phone:	Cell Phone:	Work Phone:
Marital Status: Single Married Divorced Widowed	Email Address:	Social Security Number:
Occupation:	Employer:	
Employment Address:		
City/State/Zip:		
Emergency Contact:	Emergency Contact Phone:	Relationship to Patient:

Primary Language: English Spanish Other (Please specify):	Hispanic / Latino: Yes No	Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

Pharmacy Name:	Pharmacy Phone:
Pharmacy Address:	

Guarantor Information

The guarantor is the responsible party for the patient. The guarantor is responsible for all charges not covered by insurance.

Check here if the patient is the guarantor.

Last Name:	First Name:	MI:
Address:		
City/State/Zip:	Relationship to Patient:	
Phone:	Date of Birth:	Social Security Number:

Primary Care Physician and Referring Physician Information

Primary Care Physician:	Phone:
Address:	
Referring Physician:	Phone:
Address:	

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A Clinical, Research and Teaching Affiliate
of the Warren Alpert Medical School of Brown University

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Patient First Name:
Date of Birth:

Insurance Information			
Is this visit work related? Yes No	If yes, authorization Number:		
Primary Health Insurance		**Secondary Health Insurance**	
Insurance Name:		Insurance Name:	
Policy #	Group #	Policy #	Group #
Policy Holder's Name:		Policy Holder's Name:	
Policy Holder's Date of Birth:	Policy Holder's Social Security #:	Policy Holder's Date of Birth:	Policy Holder's Social Security #:
Policy Holder's Employer:	Relationship to Patient:	Policy Holder's Employer:	Relationship to Patient:

If **Medicare is secondary**, please select appropriate reason code:
- 12 Working age beneficiary/spouse with employer group health plan
- 13 ESRD beneficiary in the 12 month coordination period with an employer group health plan
- 42 Disabled beneficiary under age 64 with Large Group Health Plan
- 15 Workers Compensation
- 41 Black Lung
- 42 VA
- 47 Any liability insurance

AUTHORIZATION and RELEASE OF INFORMATION

Initial:

_______ I am giving University Surgical Associates permission to ask for third party payor/Medicare payments for my medical care. I understand that third party payor/Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to third party payor/Medicare and the companies that handle third party payor/Medicare payment requests. I understand that the CENTERS FOR MEDICARE/MEDICAID SERVICES (CMS) is the government Medicare agency. I request that payment of authorized third party payor/Medicare benefit be made either to me or on my behalf for any services furnished me by USA, including physician services. I authorize any holder of medical or other information about me to release to the CMS and its agents any information needed to determine these benefits or benefits for related services.

_______ I understand that University Surgical Associates may obtain my prescription history from my pharmacy, other healthcare exchanges as well as querying the state prescription drug monitoring program.

_______ University Surgical Associates patient portal is a secure, confidential, HIPAA compliant communication tool. It is an optional service and you may enroll at any time. The portal is designed to enhance patient-physician communication. Access to this secure patient portal is an optional service. I may suspend or terminate it at any time for any reason. I acknowledge and fully understand the risks associated with online communication. I acknowledge that using the portal is voluntary and will not impact the quality of care I receive. I agree to adhere to the policies set forth in this agreement. I understand this consent will expire in 12 months and I will be required to sign and update my form. I will notify the office if there is any change in my email address or if I feel my password has been breached. I agree not to hold University Surgical Associates liable for infractions beyond its control. By signing below, i give permission to University Surgical Associates to enroll me in the patient portal.

_______ I have received University Surgical Associates' Notice of Privacy Practices.

Patient Signature (or guarantor if under 18):	**Date:**

Permission to Disclose Medical Information

I hereby authorize University Surgical Associates office to speak to the following people regarding my medical condition:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

I understand I may revoke this permission at any time by informing the physician's office in writing.

Patient Signature (or guarantor if under 18):	**Date:**

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