CarePoint Health
Medical Group

PATIENT REGISTRATION FORM

Today's Date:

Referring Physician:			PCP:	

PATIENT INFORMATION

Patient's last name: First: Middle:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
(Former name):	Social Security no.:	Main phone no.: ( )	Birth date: / /	Age: Sex: ❑ M ❑ F
Street address:		Main Language: Interpreter Preferred: ❑ Y ❑ N		Race: Ethnicity:
City: Occupation:	State: Employer:	ZIP:		Name Of Pharmacy:
Legal Guardian: ( ) Self ( ) Other Day to Day Caregiver ( )Self ( ) Other	Advanced Directive ( )Y ( ) N If No- Would you like additional info: ( ) Y ( ) N			Pharmacy Phone: ( )

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Main phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Please indicate primary insurance:

Policy no: Group no:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION, PARTICIPATION IN THE NJIIS AND THE ELECTRONIC SUBMISSION OF PRESCRIPTIONS

PRINT PATIENT NAME _____ MEDICAL RECORD # _____

HOME ADDRESS _____

SS# _____ DATE OF BIRTH _____ TELEPHONE _____

1. I hereby authorize _____ to release information from my medical record to:

NAME _____ ADDRESS _____ TELEPHONE _____

2. For the purpose of: (please check one)

__ Continued Treatment __ Attorney __ Insurance __ other (please list: personal reasons, etc.) _____

3. Description of information to be released (please check specific items)

__ Abstract __ Emergency Room Record __ Diagnostic test (e.g. Lab, X-Ray, and Radiology), please specify _____

-- Inpatient Record __ Outpatient Record Please specify _____ _____ __ Other_____

Covering records from on or about (date) _____ to (date) _____

CONFIDENTIAL INFORMATION

4. If the requested portion of the record contains information pertaining to the treatment for abuse, physical and/or mental illness, drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

_____ I understand that if my record contains information pertaining to the treatment for abuse, physical and/or mental illness, drug or alcohol treatment, such information will be released pursuant to this consent.

_____ I understand that if my record contains information contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV information is any information indicating that a person had an HIV related test, or has an HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

_____5. This authorization to obtain medical records will automatically expire within 90 days from the date of signature.

_____6. I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.
I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.
I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above. There is no cost to participate in this program.

_____7. ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy.
The medication history information would include medications prescribed by your health care provider at Carepoint Health Medical Group as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information***
By signing this consent form you are agreeing that your provider at CarePoint Health Medical Group may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.