# NEW PATIENT REGISTRATION FORM

| **Reason for today's visit:** | | |
|---|---|---|
| **Was this a result of a Car Accident?** ☐ **YES** ☐ **NO** | **Was this a result of a Job Injury?** ☐ **YES** ☐ **NO** | **Accident/Injury Date:** |

## PERSONAL INFORMATION

Patient Name: _____ DOB: _____

Sex: ☐ Male ☐ Female ☐ Other: _____ SSN: _____

Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Best form of contact? ☐ Home ☐ Cell

Email: _____

Pharmacy: _____ Address: _____

Primary Care Physician: _____ How Did You Hear About Us? _____

## RESPONSIBLE PARTY FOR ANY PATIENT UNDER 18

Name: _____ DOB: _____ Sex: ☐ Male ☐ Female

Address (if different than patient): _____

Phone: _____ Relationship to Patient: _____

## EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

## INSURANCE INFORMATION (only fill out if you do not have a physical copy of your card)

Primary INS: _____ Secondary INS: _____

Policy/ ID #: _____ Policy/ ID # _____

Group #: _____ Group #: _____

Subscriber/ DOB: _____ Subscriber/ DOB: _____

## HIPAA CONSENT

Preferred Phone Number for follow up: _____ Leave a Message ☐ YES ☐ NO

You may discuss my personal health information with: _____

(Name) (Relationship) (Phone Number)

## AUTHORIZATION AND RELEASE

**Authorization for Treatment**: I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent.

**Assignment of Benefits:** I authorize payment directly to HMH URGENT CARE MANAGEMENT PC for all benefits otherwise payable to me.

**Guarantee of Payment**: I understand that I am financially responsible and agree to pay all charge that are not paid or billed to insurance or any other third-party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co-pays, coinsurances and deductibles today. If you are unable to verify my insurance at the time of service, I will pay in full for all services.

**Release of Records:** I authorize HMH URGENT CARE MANAGEMENT PC to release (verbal and in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment or other health care operation which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, continuation of care and follow-up purposes.

**Receipt of Privacy Practices**: I acknowledge that I have received and/or read the Notice of Privacy Practices of HMH URGENT CARE MANAGEMENT PC. I understand that a copy of this agreement may be used with the same effectiveness as the original.

_____ _____

Patient Signature (Parent or Guardian if under 18) Date