PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____

Address _____

_____

City **State** **Zip**

Home Phone _____
Cell Phone _____
Work Phone _____
Email_____
Best # to Contact: Home ☐ **Cell** ☐ **Work** ☐

Sex: M ☐ **F** ☐ **Birth Date** _____

SS# _____ **Marital Status**_____

Employer _____

Spouse's Name _____
If Minor – Guardian Name & Relationship

_____

Emergency Contact _____
Relationship _____
Phone _____

Date of injury, illness, or condition: _____

INSURANCE

PRIMARY _____
Phone _____
Policy # _____
Insured Party's Name _____
Relationship to Insured _____
Insured Party's Birth Date _____

SECONDARY _____
Phone _____
Policy # _____
Insured Party's Name _____
Relationship to Insured _____
Insured Party's Birth Date _____

TERTIARY _____

Was this injury work related? Y ☐ **N** ☐
Was this injury automobile related? Y ☐ **N** ☐
Claim ☐ **No Claim** ☐
Adjuster _____
Company _____
Phone _____
Fax _____
Claim # _____

Primary Care Physician: _____ **Phone:** _____
Referring Physician: _____ **Phone:** _____

Release of information: I authorize any physician, hospital, pharmacy, insurance co., employer, or organization to release any information regarding the medical history, or benefits payable for this claim to any organization responsible for payment of this claim or to any physician or medical service organization who will render care to the patient. I hereby give my consent for D&J Medical to use any photographs or videotape of me for educational and/or insurance claim processing purposes. **Insurance Certification and Assignment:** I certify that the information given by me in applying for payment under titles XVII and XIX of the Social Security act, by my insurers, and any third party payers, is correct. I authorize payment of medical benefits to D&J Medical for the services rendered. I authorize the use of the below signature on all insurance submissions. **Responsibility agreement:** I acknowledge financial responsibility for this account. I understand that I am responsible for payment of any health insurance deductible(s), coinsurance, or any other charges incurred which are not paid by my insurers or other third party payers. Should this account be referred to an attorney or agency for collection, the undersigned shall pay reasonable attorney fees and collection expenses. It is understood that all judgments in a court of law may bear interest at the legal rate.
Statement to permit payment of Medicare benefits to provider, physicians, and patients: I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by D&J Medical including physician services. I authorize any holder of medical or other information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or benefits for related services. **Medigap Policy:** Authorization request that payment of authorized Medicare benefits be made on my behalf to D&J Medical for any services furnished me by D&J Medical. I authorize any holder of medical information about me to release to the Center for Medicare& Medicaid Services and its agents any information needed to determine benefits.
Email Privacy Policy: We will not sell, share or lease your personal information to third parties.
Medicare DMEPOS Supplier Standards: The products and/or services provided to you by D&J Medical are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

Relationship to patient:
_____

x_____
Patient (Beneficiary) or Authorized Representative

Reason if unable to sign:
Minor_____Physical_____

_____
Date

_____
Address of Authorized Representative

Acknowledgement of Receipt of Notice of Privacy Practices I certify that I have received a copy of D&J Medical notice of privacy practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of D&J Medical health care operations. The Notice of Privacy Practices also describes my rights and D&J Medical duties with respect to my protected health information. The Notice of Privacy Practices is posted in the patient waiting room. D&J Medical reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

In accordance with HIPAA regulations, you may also share my information with: ☑ **Emergency Contact**

_____**and/or** _____

x_____ _____
Patient (Beneficiary) or Authorized Representative **Date**