Ashton Family Medicine & Wellness Center

----- A DIVISION OF PINNACLE PHYSICIAN'S GROUP, LLC.

PATIENT REGISTRATION INFORMATION

TODAY'S DATE: / /

DO TO NEW REGULATIONS, WE ARE REQUIRED TO ASK FOR THE FOLLOWING DEMOGRAPHIC INFORMATION FROM YOU. PLEASE FILL IN ALL INFORMATION. IF YOU PREFER NOT TO ANSWER A QUESTION – PLEASE DO NOT LEAVE IT BLANK, PLEASE STATE THAT YOU PREFER NOT TO ANSWER.

NAME _____ **DATE OF BIRTH** _____

MAILING ADDRESS_____

CITY _____ **STATE** _____ **ZIP** _____

PREFERRED PHONE ( )_____ - _____ ☐**HOME** ☐**MOBILE** ☐**WORK**

ALTERNATE PHONE ( )_____ - _____ ☐**HOME** ☐**MOBILE** ☐**WORK**

EMAIL ADDRESS _____@_____

SOCIAL SECURITY # _____-_____-_____ **DRIVER'S LICENSE #** _____ **STATE**____

GENDER: _____ **RACE:** _____ **ETHNICITY:** ☐**HISPANIC** ☐**NON-HISPANIC**

PREFERRED SPOKEN LANGUAGE: ☐**ENGLISH** ☐**SPANISH** ☐**OTHER** _____

MARITAL STATUS: ☐**SINGLE** ☐**MARRIED** ☐**DIVORCED** ☐**WIDOWED** ☐**SEPARATED**

PRIMARY CAREGIVER (WHO SHOULD RECEIVE INSTRUCTIONS ON YOUR CARE IF NOT YOURSELF)
☐**SELF** _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTH CARE PROXY TO MAKE MEDICAL DECISIONS FOR YOU SHOULD YOU NOT BE ABLE TO YOURSELF?

☐**YES** ☐**NO** (ANSWER SHOULD ALWAYS YES FOR A CHILD UNDER 18)

IF YES WHO?_____

WHAT IS THEIR RELATIONSHIP TO YOU? _____

WHAT IS THEIR CONTACT PHONE NUMBER? ( ) _____ - _____

DO YOU HAVE AN ADVANCED DIRECTIVE or "LIVING WILL" THAT STATES YOUR WISHES SHOULD YOU NOT BE ABLE TO MAKE MEDICAL DECISIONS FOR YOURSELF?
☐**YES** ☐**NO** IF YES PLEASE PROVIDE A COPY TO A CARE TEAM MEMBER.

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT? _____

PHONE #( ) _____ - _____

NAME _____ DATE OF BIRTH _____

PLEASE PRESENT YOUR INSURANCE CARD TO A FRONT OFFICE CARE TEAM MEMBER SO A COPY OF YOUR CARD CAN BE MADE FOR OUR RECORDS.

INSURANCE COMPANY _____

POLICY HOLDER ☐SELF ☐SPOUSE ☐PARENT ☐OTHER _____

POLICY HOLDER'S NAME _____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits, to which I am entitled, including Medicare, private insurance and any other health plan to Richard S. Mandel, PC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signed _____ Date / /

HIPPA INFORMATION

I have received the HIPPA Notice of Privacy Practices and I understand my rights under these practices.

Signed _____ Date / /

RELEASE OF RECORDS

I authorize the physicians of Ashton Family Medicine to seek out and receive my medical records for any treatment I received at any physician's office or health care facility prior to today and in the future until this privilege is revoked by me in writing.

Signed _____ Date / /