Today's Date _____/_____/_____ Patient Registration Form: Please Print Clearly

Last Name _____ First Name_____ MI ___ Date of Birth ____/____/_____

Address _____ City_____ State _____ Zip _____

Home Phone (_____) _____ Cell# (_____) _____ Work PH# (_____) _____

SS# _____ ___ - ___- ___ ___ Gender: M ___ F ___ (Student Y__ N__) Single __ Married __ Divorced __ Widowed __

Name of Employer _____ Date of Hire _____/_____/_____

Name of Spouse _____Spouse Work phone# (_____) _____

Email address: _____If no insurance check here ___

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Policy Holder Info *If different from patient, please complete:*

Last Name _____ First Name_____ MI ___ Date of Birth ___/___/_____

Address _____ City _____ State ____ Zip _____

Home #(____) _____ Cell # (_____) _____ Work PH#(_____) _____ SS# __ __ __ - __ __ - __ __ __ __

Gender: M __ F __ Name of Employer _____Date of Hire _____/_____/_____

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Who lives in your household? **Name: _____ Age:_____**

Name: _____ Age: _____ Name: _____ Age:_____

Name: _____ Age: _____ Name:_____Age:_____

Name:_____Age:_____ Name: _____ Age:_____

Individuals we can share your medical info with (Please list emergency contact first)

Name: _____Phone: (_____)_____ Relationship to Patient: _____

Name: _____ Phone: (_____)_____ Relationship to Patient: _____

Name: _____ Phone (_____)_____ Relationship to Patient: _____

Name: _____ Phone: (_____)_____ Relationship to Patient: _____

Signature of Person Authorizing Information Release and Payment Authorization **I understand that sometimes my insurance company does not pay for certain medical care which might include lab work, physicals, or certain procedures. If this happens I will be responsible for payment to Geauga Family Physicians. I understand that if there is no payment after two statements, my account will be submitted to a collections agency with an additional $15.00 charge.**

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***Patient Consent Form of Our Privacy Notice Required by HIPAA*, The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. You have the right to review an explanation of this privacy notice which is located in a folder in our waiting room. I also understand that sometimes my medical information will be sent to specialists, hospitals, or other facilities or pharmacies and I give authorization to Geauga Family Physicians to follow through with my medical care as they deem medically necessary. We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, or other healthcare operations. This is a voluntary agreement. You may opt-out at any time from the Health Information Exchange by notifying our office staff. Often our office will call your home and find you not at home. Completing this form allows us to leave a message on your voice mail or answering machine regarding your medical information. I wish to be contacted in the following manner (Please Check All That Apply):**

___ **Home telephone** (____)_____

___ OK to leave message with detailed message

___ Leave message with call back number

___ **Work Telephone** (_____)_____

___ OK to leave message with detailed information

___ Leave message with call back number only

___ **Written Communication**

__ OK to mail medical info to home address

__ OK to FAX to this number _____

__ **Cell phone** (_____)_____

___ OK to leave message with detailed information

___ Leave message with call back number only

Patient's Signature: _____

If Minor Print Parent's /Guardian's Name:_____

If Minor Parent's /Guardian's Signature: _____

Form Updated 3/16/2016 ***This form will be placed in the patient's medical chart***