CROZER KEYSTONE HEALTH SYSTEM

Crozer-Keystone Health Network

Patient Registration Form

(for office use only: HIPAA)

Privacy Notice Date: _____

Today's Date:

Patient Information

Social Security #:

Patient Name: (last, first, middle) (maiden)

Patient Address:

City	State	Zip Code

Home Phone: ( )

Cell Phone: ( )

Employer:

Employer Address:

City	State	Zip Code

Work Phone: ( )

Occupation: ☐ Full Time ☐ Part Time

Primary Insurance Information

Insurance Company Name:

Address:

Policy Number:	Group Number:
Policy Holder Name:	**Date of Birth:**

Policy Holder Social Security #:

Relationship of Patient to Policy Holder:

Employer of Policy Holder: ☐ Full Time ☐ Part Time

Address:

City	State	Zip Code

Telephone #: ( )

Additional Information

☐ Person responsible for bills (if other than patient) ☐ Related Party

Name:	Date of Birth:

Address:

Relationship to Patient:
☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Child
☐ Life Partner ☐ Other Family Member

Referring Physician (if not primary care physician)

Name:

Address:

City	State	Zip Code

Telephone #: ( )

Primary Care Physician (for Specialty Offices only)

Name:

Address:

City	State	Zip Code

Telephone #: ( )

Patient Information

Gender: ☐ Male ☐ Female	Date of Birth:	Age:

Marital Status:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: (for medical purposes – optional)
☐ African American ☐ White ☐ Hispanic ☐ Asian ☐ Other

Religion: (for medical purposes – optional)

Student Status Information

Student? (18-23 yr. old)	☐ Yes ☐ No	☐ Full Time ☐ Part Time

Name of School:

Emergency Contact

Name:

Relationship:

Telephone #: ( )

Secondary Insurance Information

Insurance Company Name:

Address:

Policy Number:	Group Number:
Policy Holder Name:	**Date of Birth:**

Policy Holder Social Security #:

Relationship of Patient to Policy Holder:

Employer of Policy Holder: ☐ Full Time ☐ Part Time

Address:

City	State	Zip Code

Telephone #: ( )

Living Will

Do you have a living will? ☐ Yes ☐ No

If no, would you like information? ☐ Yes ☐ No

Additional Information

Are you allergic to latex? ☐ Yes ☐ No

May we call your work? ☐ Yes ☐ No

May we call your home? ☐ Yes ☐ No

May we leave a message on your answering machine to:

- **Remind you of appointments?**
- **Ask you to call the office back?**
- **Inform you a prescription has been called in to your pharmacy?**

☐ Yes ☐ No

May we leave a message with a member(s) of your household for the reasons above? ***(****We are not allowed to give others your medical information****).*** ☐ Yes ☐ No

If yes, please list the name(s):

CONSENT FOR OUTPATIENT SERVICES

I consent to examination, routine testing and medical treatment, which my doctor and/or other doctors who care for me believe is necessary. I understand medicine is not an exact science; no guarantees or promises have been made to me about my treatment. I accept that the services provided are given in the least restrictive setting and manner to meet my needs. If special procedures are needed, I will be asked by my doctor to give separate informed consent. I have the right to refuse any drugs, treatment, or procedures. I understand that neither the Hospital nor my doctor is responsible for my personal belongings during my care. I have read and understand this consent for care and my questions have been answered. My signature means I agree to the above. I can ask for a copy of this form.

_____ _____

PATIENT/ AUTHORIZED PARTY DATE PRINT NAME DATE

_____ _____

RELATIONSHIP TO PATIENT WITNESS NAME & INITIALS DATE

ASSIGNMENT OF HEALTH INSURANCE BENEFITS AND AGREEMENT FOR FINANCIAL RESPONSIBILITY

I authorize payment to my doctors and/or hospital of any health insurance benefits that are payable to me, including Medicare and/or Medicaid payments, Medigap payments, and/or payments under any Employer Self-Funded Medical Expense Reimbursement Plan as governed by the Employee Retirement Income Security Act (ERISA), and/or payments from private insurance companies. I certify that the information that I gave to my doctors and/or hospital to bill for payment is correct. I assign and transfer to Crozer-Keystone Health Network, my doctors and/or hospital or their agents the right to act in my place to bill and collect all payments that are payable to me under any private or government plan of health benefits and/or to sue any insurer or other responsible party to obtain these payments. These payments may not be more than the balance due my doctors and/or hospital and I understand that I have to pay my doctors and/or hospital for all charges not paid by my health insurance. This payment authorization, assignment of benefits and agreement for financial responsibility is also binding on my administrators, executors, heirs and successors.

I have read this assignment of benefits; I understand this assignment of benefits, and my questions have been answered.

_____ _____

PATIENT/ AUTHORIZED PARTY DATE WITNESS NAME AND INITIALS DATE

AUTHORIZATION TO RELEASE INFORMATION FOR TREATMENT, PAYMENT OR OPERATIONS

I understand the hospital and/or my doctor may use and disclose my health information for treatment, payment, or operations in accordance with the Crozer-Keystone Health System's Notice of Privacy Practices ("Privacy Notice") and I authorize the use and disclosure of my health information in accordance with the Privacy Notice.

I understand that if I am treated for HIV, drug and alcohol abuse, or mental health issues that this information will not be released without my specific written consent relating to these conditions. My signature below means that I have read this authorization and I understand this authorization to release my health information.

_____ _____

PATIENT/ AUTHORIZED PARTY DATE WITNESS NAME AND INITIALS DATE

If consent from the patient is verbal because of the patient's physical inability to sign this consent form, then please check this box and have a staff member sign as a witness above and a second witness sign here.

☐ _____

SECOND WITNESS' NAME DATE

NOTICE OF PRIVACY PRACTICES

My signature below means that I have received a copy of the Crozer-Keystone Health System's Notice of Privacy Practices, which explains in more detail my rights to, and some of the uses and disclosures of my health information.

_____

PATIENT OR AUTHORIZED PARTY DATE