Dr. Rodolfo C. Reyes/Emily Amoni, PA-C/Ashley Cothran, PA-C/Barry Spiegel,PA-C

REGISTRATION FORM

First Name: _____ MI:____Last Name: _____

DOB: _____Age: _____SSN: _____ Sex: M F

Marital Status (Circle One): Single Married Divorced Separated Widowed

Ethnicity: Hispanic or Latino__ Not Hispanic or Latino__ Unknown/Declined__

Check all that applies:

Race: ___American Indian or Alaskan Native __ Asian__ Black or African American __ Native Hawaiian or Native Pacific Islander__ Other Race__ White __ Unknown/Declined

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Name of Pharmacy Used: _____

Emergency Contact: _____

Insurance Information

Name of Insurance Company: _____

Name of Policy Holder: _____

Policy ID Number : _____

Group #:_____

Policy Holder's Date of Birth: _____

Policy Holder's SSN#: _____

I, The undersigned certify that I (or my dependent) have insurance coverage and assign directly to Edgewater Medical Center & Urgent Care all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature **Relationship** **Date**

Signature below acknowledges that you have read a copy of the HIPPA policy. You may request a copy to keep upon request.

_____ _____ _____

Responsible Party Signature **Relationship** **Date**

HIPPA CONSENT TO LEAVE MESSAGE

Patient Name: _____ Date of Birth:_____

We must call on occasion to discuss confidential protection health information. Below is a list of potential ways for us to communicate this information. Know that even if you select for us to leave a message with protected health information, it may be at our discretion how much information we will leave. Please indicate how you would like us to get this information to you:

Its okay to leave a message with protected health information on voice-mail or to person answering by calling (check if "yes"):

__ Home phone number
__ Mobile/Cell number
__ Work phone number

This authorization applies to the numbers you provide at registration and/or verbally change with us.

I give permission to the individual(s) listed below to receive protected health information:

__ Give information to employer : _____
__ Give information to school: _____
__ Spouse, provide name: _____
__ Parent(s), provide name: _____
__Other, provide name and relationship: _____

This authorization can be revoked or modified by notifying us IN WRITING at any time.

_____ _____
Patient/Guardian Signature Date