BACKUS HEALTH CENTER
REGISTRATION INFORMATION FORM

PATIENT NAME: _____ **SSN:** _____ **DOB:** _____

Address: _____
Street City/State Zip

Home Phone: _____ **Cell Phone:** _____ **Sex:** M F

Marital Status: S M D W **Ethnicity:** Hispanic/Latino Not Hispanic/Latino Unknown/Decline

Race: _____ **Primary Language:** _____ **Email Address:** _____

Employer: _____ **Work Phone #** _____

Emergency Contact: _____
Name Relationship Phone #

Primary Care Giver at Home: _____
Name Relationship Phone #

Health Care Representative: _____
Name Relationship Phone #

Do you have an Advanced Directive? Y N **If yes, where is it?** _____

Do you want information on Advanced Directives/Health Care Representative? Y N

Primary Care Physician: _____
Name Phone #

Other Medical Providers: _____
Name Phone #

_____
Name Phone #

PHARMACY: _____
Name Location Phone #

HEALTH INSURANCE INFORMATION: ***Please provide office with current copy of insurance card(s).***

PRIMARY INS: _____ **POLICY HOLDER:** _____
ID # _____ **POLICY HOLDER SSN:** _____
GROUP #: _____ **POLICY HOLDER DOB:** _____

SECONDARY INS: _____ **POLICY HOLDER:** _____
ID # _____ **POLICY HOLDER SSN:** _____
GROUP #: _____ **POLICY HOLDER DOB:** _____

PATIENT CONSENT AND AUTHORIZATION

I hereby authorize CONNCARE/Backus Health Center personnel and contracted staff to perform any and all tests or procedures relative to my care, injury/illness and/or physical examination as deemed necessary and advisable by the provider and/or employer

I hereby authorize the release of medical information pertaining to any occupational healthcare, provided to me at this facility, to my employer, insurance company and medical provider involved in the diagnosis.

I hereby give permission to my third party payer (Insurance carrier, PPO, HMO, employer) to directly pay CONNCARE/Backus Health Center for services rendered to me. I understand that I am responsible for any applicable balance remaining after my insurance has paid and I am to pay the difference within 30 days of notification by CONNCARE/Backus Health Center or my insurance carrier.

I have been made aware that if the physician does not participate with my health insurance plan I will be responsible for any applicable charges.

I understand and accept that I must pay for any charges which I am billed by CONNCARE/Backus Health Center. This may include any claims denied by my third party payer, including any claims denied by employer's workers' compensation insurance carrier. I understand that if these medical bills are not paid on time, they may be turned over to a collection agency. If this happens, I understand that I will have to pay, and I agree to pay reasonable collection and attorney fees in addition to lawful interest and cost.

This office participates in a community health record with The William W. Backus Hospital and members of its medical staff. A community health record is a complete patient medical record, available electronically, to all care givers at the point of care. Information associated with my visits at this practice will be automatically included in, and available through, the enterprise within the bounds of applicable federal and state laws unless I request restrictions.

This authorization will remain in effect until revoked by me in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

My signature below indicates that I have read and understand each of the paragraphs above.

DATE: _____SIGNATURE:_____WITNESS:_____

REASON FOR VISIT: _____