AtlantiCare

A MEMBER OF GEISINGER HEALTH SYSTEM

Patient Registration Form

Patient Information:
Reason for visit (if injury how did it occur):

_____

If injury, is it related to: Worker's Comp? Y / N Motor Vehicle? Y / N

Please give date of injury: --/--/----__

First Name: _____Middle initial: ____last Name: _____

Social Security # _____/_____/_____ Date of Birth: ___/___/____Age: _____

Sex M / F / T Marital Status (circle one) S M D W Partner

Address_____

City _____State _____Zip _____

Home Phone # (_____) _____Cell Phone # (____) _____

Work (___) _____-_____

Emergency Contact Information (if patient is an adult) orParent/Guardian Information (if patient is a minor):

First Name_____ Middle Initial: ___Last Name: _____

Relationship to Patient: _____Home Phone #: (_____) _____

Work Phone (_____) _____Cell phone # (____) _____

Employment Status (circle one) Full-time / Part-time / Self Employed / Retired / Military

Patient's Occupation _____Work # _____

Employer _____Address_____

City _____State _____Zip_____

Is it okay to leave messages at: Work? Y / N If Student, indicate School _____
Student Status FT/ PT

Do you have an Advance Directive? Y / N If no would you like information about it? Y / N

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Insurance Information:

Name of PRIMARY Insurance _____

If Medicare: Is the patient a Veteran? Y / N Are you currently employed? Y / N

Do you have a Federal Black Lung Card? Y / N Is your spouse/partner currently employed Y / N

Policy / Subscriber # _____ Group # _____

How is the Subscriber related to you? Self / Spouse / Child / Guardian

Policyholder / Subscriber Information:

First Name _____ Middle Initial _____ Last Name _____

Social Security # _____ /_____ /_____Date of Birth: ___/___/___Age: _____Sex M / F / T

Address _____

City _____State_____ Zip _____

Home Phone # (____) _____Cell Phone # (_____) _____

Subscriber's Employer _____

Work # (____) _____Employer's Address _____

City _____ State _____ Zip:_____

Name of SECONDARY Insurance Company _____

Policy / Subscriber # _____Group # _____

How is the Subscriber related to you? Self / Spouse / Child / Guardian/ Partner

Policyholder / Subscriber Information:

First Name _____ Middle Initial _____ Last Name _____

Social Security # _____ /_____ /_____Date of Birth: ___/___/___Age: _____Sex M / F / T

Address _____City _____ St _____Zip_____

Home Phone # (____) _____Cell Phone # (____) _____

Subscriber's Employer _____ Work # _____

Employer's Address _____

City _____State _____ Zip _____

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Additional Information

E-mail address _____preferred method of contact Home / Cell / Email

Is it okay to leave messages at: Home? Y / N Cell? Y / N

Primary Language _____ Country of Origin _____

Translator services required? Y / N

Ethnicity _____Race _____

Are you visually impaired? Y / N Are you hearing Impaired? Y / N

Pharmacy Information:

Retail Pharmacy Name: _____

Phone # (____)_____ Fax # (____)_____Location _____

ID#_____

Mail Order Pharmacy:_____

Phone # (_____)_____ Fax # (____)_____

ID #_____

Preferred lab Company:

- ☐ AtlantiCare Labs (ACL)
- ☐ Lab Corp
- ☐ Quest

New Primary Care Physician: _____

Former Primary Care Physician: _____

Referring Physician: _____

Today's Date ____/____/_____

Patient's Name: _____DOB: _____SEX_____

MEDICAL HISTORY: (please check all that apply)

High Blood Pressure	Drug Abuse
High Cholesterol	Alcohol Abuse
Diabetes	Ulcers
Cancer	Hepatitis
Tuberculosis	HIV
Urinary Tract	Thyroid
Infections	Asthma
Anemia	COPD
Kidney Stones	Stroke
Kidney Disease	Angina
Gallbladder Disease	Lyme's Disease
Heart Disease	Arthritis
Depression	Other (please describe)

Do you have any Allergies to Medication, food or other: Y / N

Surgical History: (please list type of surgery, if any, and date)

Family History: (please check all that apply)

Blood Pressure	Stroke
Diabetes	Heart Attack
Cancer	Kidney Disease
Mental illness	Depression
Other (please describe)	Drug or Alcohol use

Social History

Alcohol: **Y / N**	If yes, how many drinks are consumed, per week? _____
Cigarettes: **Y / N**	If yes, how many packs per day? _____
Drug/Substance use: Y / N	

Immunizations

Flu Vaccine _____ TDAP _____ Pneumonia Vaccine _____

Other treating providers: (please list the name and specialty of any other provider currently treating you)

Name: _____ Specialty: _____

AtlantiCare
PRIMARY CARE PLUS

Today's Date: _____/ _____/ _____

Patient Name: _____ DOB: _____/ _____/ _____

Please list all medications including vitamins and over the counter supplements and medications

Medication	MG/ Strength	Dose/ How Often

***NOTE:** It is always best to bring in your all medication, supplements and vitamins to all your medical visits.

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I hereby authorize _____

(Name of health care organization or physician)

To release the health information of:

PATIENT NAME: _____ **Date of Birth** _____

Information is to be released from records pertaining to:

- ❍ Ambulatory ❍ Inpatient ❍ Emergency Department
- ❍ Other_____

For date(s) of service:_____

Specific information to be released:

- ❍ Complete Medical Record ❍ Laboratory tests ❍ Radiology ❍ Cardiac tests
- ❍ Ophthalmology report ❍ Other_____

The purpose for this release is for patient treatment.

Information is to be released to:

Information is to be released for the purpose of treatment and continuity of care.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare' compliance with this request. The revocation must be in writing and is subject to terms described in AtlantiCare Notice of Privacy Practices and other AtlantiCare policies.

I understand that I am not required to sign this authorization and that AtlantiCare may not condition treatment or services on my execution of this authorization.

I understand that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protected by HIPAA.

This authorization will expire upon the release of the information described above or one year (12) months after the date of the authorization, unless specified otherwise.
Expiration date: _____

_____

Signature of Patient or Personal Representative Date

Personal Representative's relationship to Patient: _____
Patient is unable to sign because

Patient is entitled to a copy of signed authorization.

Updated 04/01/2014 IV

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the AtlantiCare entity indicated below

☐AtlantiCare Behavioral Health	☐AtlantiCare Health Services
☐AtlantiCare Regional Medical Center	☐AtlantiCare Foundation
☐AtlantiCare Surgery Center	☐AtlantiCare Health Plans
	☐InfoShare

To release the health information of:

PATIENT NAME: _____ DOB _____

To the person or entity listed below:

Recipient's name: _____
Recipient's address: _____
_____
Recipient's Phone: _____
Recipient's Fax: _____

Information is to be released from records pertaining to:
☐Ambulatory ☐Inpatient ☐Emergency Department ☐
Other_____

For date(s) of
service:_____

Specific information to be released:
☐Complete Medical Record ☐Laboratory tests ☐Radiology ☐Cardiac tests

Other:_____
_____
_____

Information is to be released for the purpose of:_____
_____

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations. I understand that I have the right to revoke this authorization at any time prior to the requested entity's compliance with request. The revocation may be subject to the entity's Notice of Privacy Practices and other policies.

I understand that I am not required to sign this authorization and that AtlantiCare may not condition treatment or services on my execution of this authorization.

I understand that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protect by HIPAA.
This authorization will expire upon the release of the information described above or 6 months after the date of the authorizations, unless specified otherwise: Expiration date: _____

Signature of patient or personal representative: _____Date:

Personal representative's relationship to patient_____
Patient is entitled to a copy of signed authorization.

Consent to discuss Care & Treatment

Patients Name: _____Birthdate: _____/_____/_____

Practice Name_____ Primary Provider _____

I permit the following information to be discussed with the following family member, friend or others person or persons listed below.

I understand that if I want any of the persons listed below to receive a copy of my records; I must complete and sign a separate authorization form.

In an emergency or if I am admitted to the hospital and unable to make my wishes known, I understand that my provider and hospital staff may rely on the above permissions to determine with whom they may discuss my care.

I can change the permissions stated below at any time by notifying my provider or AtlantiCare's Privacy office.

☐ Appointments only
☐ Results/ Plan of care _____
☐ My bill Name Relationship Phone

☐ Appointments only
☐ Results/ Plan of care _____
☐ My bill Name Relationship Phone

☐ Appointments only
☐ Results/ Plan of care _____
☐ My bill Name Relationship Phone

Patient signature_____Date_____

Print name_____

Signature of lawful personal representative* _____Phone_____

Print name_____

*Required only if the patient is a minor or unable to represent self.