Cary Healthcare Associates, P.A.

PATIENT REGISTRATION FORMS

Name_____
Last First MI

Date of Birth: _____ Age_____ Social Security#_____

Address: _____
Street City State Zip

Mailing Address if Different: _____

Home#_____ Cell#_____ Work#_____ ext:_____

E-mail_____

Emergency Contact Person and Phone #_____

Parent's Name (If Patient is a Minor):_____

Mother: _____ Father:_____

Patient Gender: _____ Marital Status: _____ Spouse Name (If applicable) _____

Language: English Spanish Other:_____

Race and Ethnicity: (Requested per Federal Guideline) Please circle one:

Ethnicity: Hispanic Non- Hispanic

Race: American Indian or Alaska Native Asian Native Hawaiian

Black or African American White Hispanic Other

Employer and Occupation:_____

PRIMARY Insurance:_____
Policy Holders Name:_____ Date of Birth_____
SS# of Policy Holder_____ Relationship to Patient_____
Policy#_____ Group#_____ Effective Date:_____

Secondary Insurance: _____
Policy Holders Name: _____ Date of Birth_____
SS# of Policy Holder_____ Relationship to Patient_____
Policy#_____ Group#_____ Effective Date: _____

I authorize Cary Healthcare Associates to send prescriptions and retrieve medication history electronically.
Patient's Signature _____

Pharmacy Name: _____ Pharmacy#_____

Cary Healthcare Associates, P.A.

PATIENT REGISTRATION FORMS

Compound Authorization for Release of Information

Rights of the Patient
Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving permission to share your health information with the person you have indicated below.
This authorization is voluntary.
Right to revoke: If you decide you do not want us to share your health information any longer you must sign a revocation form.
The information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
Payment, enrollment or eligibility benefits of your healthcare will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations.

Print Name: _____ DOB: _____

I give permission to Cary Healthcare Associates, P.A. to share my health information with: (Write name and relation)

_____

_____

_____

May we leave a voicemail with information? Yes or No

Cary Healthcare Associates, P.A. may share my health information on this authorization form until this date of_____, or until I revoke the authorization in writing.

☐ All of my health care information ☐ Lab tests/ x-rays

☐ Information regarding prescription drug coverage

☐ Financial billing information

_____ Date:_____
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach documentation)

Minor's Medical Treatment:

Child's Name: _____ Child's Date of Birth: _____
I being the parent or guardian of the above child, request and authorize any physician, nurse practitioner, or physician assistant at Cary Healthcare Associates and his/hers staff to perform all necessary medical care to my child, whether or not I am present at the appointment.

I authorize the following individuals to obtain medical care for this child, in my absence:

_____ _____
Name Relationship to Child

_____ _____
Name Relationship to Child

Signature of Parent or Guardian: _____ Date: _____