Barnabas Health Medical Group | RWJBarnabas HEALTH

Today's Date: _____

Patient ID # _____ [for office use only]

Referring Physician _____

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: M □ F □ Social Security #: _____

For Minors please indicate responsible Parent/Guardian: _____

Address: _____
Street City State/Zip

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Email: _____ Driver's License #: _____

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

Employer: _____ Occupation: _____

Emergency Contact: _____ Telephone: _____

How did you hear about us?

Please check as many corresponding boxes that apply:

Website	□	Facebook	□
Google/Yahoo/Bing	□	Other Internet Ad	□
Newspaper/Magazine Ad	□	Direct mailing (letter, post card, etc.)	□
Friend or family_____	□	Physician	□
Other (e.g., CVS)_____	□		

I would like to receive email newsletters, general health tips and information from Barnabas Health: Yes □ No □
If Yes, please provide email address: _____

Responsible Party
Complete Only if Patient is Not the Responsible Party

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Insurance Information (Present Insurance Card(s) to Receptionist)

Primary Insurance: _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Effective Date of Primary Insurance: _____

Subscriber Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Secondary Insurance: _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Effective Date of Secondary Insurance: _____

Subscriber Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Demographic Information Request

In order to comply with federal regulations, we are required to ask you for the following information:

Race
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or Other Pacific Islander
□ White
□ Patient Declined

Ethnicity
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Patient Declined

Advance Directives

Do you have a health care proxy/living will? □ Yes □ No Do you want to discuss this with your physician? □ Yes □ No

Smoking Status

Please indicate your smoking history:

□ Never Smoked □ Past Smoker □ Current smoker – Indicate how many and how often you smoke _____

Communication Preferences

I understand that the staff and/or physicians of Barnabas Health Medical Group ("BHMG") may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Preferred Language _____ Preferred method for communication: □ Home □ Work □ Cell

Can we leave a message on machine or with whoever answers? (Circle **Yes** or **No**) **Home** Y / N **Work** Y / N **Cell** Y / N

DO NOT CALL: □ Home □ Work □ Cell

Disclosure to Designated Family/Friends/Caregivers

I allow BHMG to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing any time.

Print Name	Date of Birth	Relationship	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____

Preferred Pharmacy

Please indicate your preferred Pharmacy /Pharmacies below:

Pharmacy Name: _____ Phone Number: (_____) _____

Address: _____

_____

(Indicate City and Cross Streets, Zip Code, if known)

Pharmacy Name: _____ Phone Number: (_____) _____

Address: _____

_____

(Indicate City and Cross Streets, Zip Code, if known)

Authorization to Access Electronic Prescription Records

I authorize Barnabas Health Medical Group ("BHMG") and its affiliated providers to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my BHMG medical record.

Health Information Exchange (HIE)

BHMG also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize BHMG and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs, and instructions on how to do that can be found in the BHMG Notice of Privacy Practices, the HIE brochure which is available from participating BHMG offices, or may be requested from BHMG's Privacy Officer.

Authorization for Photographs and Release for use in Medical Records

I hereby authorize and consent to the taking of photographs and moving pictures of me by BHMG, its agents or employees. I hereby authorize and consent to the use and storage of such photographs and moving pictures for identification purposes and as part of my medical record.

I hereby release BHMG, its medical staff, agents and employees from all liability related to the making, storage, and use of such photographs and moving pictures for identification purposes and as part of my medical record.

Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the providers in BHMG for services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments and benefits services that are out of network, denied and/or not covered by my health insurance plan. I authorize BHMG or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

Consent to Treat

I, the undersigned, voluntarily consent to and authorize BHMG through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my BHMG physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

Acknowledgments and Agreement

- I acknowledge that I have been advised of my right to an Advance Directive.
- I acknowledge receipt of the BHMG Financial Policy, and agree to all the terms and conditions contained therein.
- I acknowledge receipt of the Notice of Privacy Practices.
- I agree to allow access to my electronic prescription records as described above.
- I agree to the release and assignment of benefits as described above.

- I agree to treatment as described above.
- I have read this form, my questions have been answered, and I understand and agree to its content.

_____ _____

Patient/Representative's Signature Date

_____ _____

If signed by Authorized Representative, print name of Signatory Relationship to Patient/Authority to Sign for Patient