PATIENT REGISTRATION/RELEASE AUTHORIZATION

INNOVATIVE PRIMARY CARE

Thank you for choosing our office for your healthcare needs. In order to serve you properly, we ask that you complete this form. All information will be strictly confidential. Please print responses.

Today's Date:		
Patient Information		
Patient Last Name: (as it appears on Insurance Card)	Patient Middle Name:	Patient First Name:
Birthdate:		Gender:
Marital Status: (please circle one) Single Married Divorced Separated Widowed Partner		
Mailing Address:		
City:	State:	Zip:
Social Security Number:	Email Address:	
Home phone:	Cell phone:	Work phone:
Primary phone number for follow up purposes (please circle one)? Home Cell Work		
Preferred method of communication for appointment reminders (please circle one): Phone Text Email		
I'm interested in signing up to use the Patient Portal (please circle one): Yes No		
How did you learn about Innovative Primary Care? (please circle one): Online search Print Advertisement (Natural Awakenings, etc.) Friend/Family Other:		
Insurance Information		
Primary Insurance:	Policy #:	Group #:
Effective Date:	Co-Pay/Deductible:	
Patient's relationship to subscriber (please circle one): Self Spouse Child Other		
Person Responsible for bill (if different than patient):		
Birthdate of Responsible Person:		Address:
City:	State:	Zip:
Primary Phone Number:		Is this person an IPC patient: Yes/No
Secondary Insurance:	Policy #:	Group#:
Effective Date:	Co-Pay/Deductible:	
Patient's relationship to subscriber (please circle one): Self Spouse Child Other		
Person Responsible for bill (if different than patient):		
Birthdate of Responsible Person:		Address:
City:	State:	Zip:
Primary Phone Number:		Is this person an IPC patient: Yes/No

-more on reverse-

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Name:	Today's Date:

Optional Demographic Information
Race/Ethnicity (please circle one): Hispanic/Latino American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White

Emergency Contacts		
Emergency Contact Name:	Emergency Contact Phone:	HIPAA Approved?
Relation to you:		
Emergency Contact Name:	Emergency Contact Phone:	HIPAA Approved?
Relation to you:		

To protect your privacy as outlined by HIPAA (Health Information Portability Accountability Act), please indicate below who we may release medical information to. Please include their name and relationship to the patient.

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Please indicate below anyone we may NOT release medical information to.

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Please initial the following statements:

_____ The above information is true to the best of my knowledge.

_____ I authorize my insurance benefits to be paid directly to the physician.

_____ I understand that I am financially responsible for any balance on my account.

Patient or Guardian Signature: _____

Patient or Guardian Name (Print): _____

Date: _____

**Failure to sign the above acknowledgements may result in having to reschedule your appointment until a signature is obtained.*

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