Today's Date _____

Patient ID _____

(for office use only)

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 □

Google/Yahoo/Bing □

Newspaper/Magazine Ad □

Friend or family □

Facebook/Instagram □

Other Internet Ad □

Direct mailing (letter, post card, etc.) □

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 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: ( ) _____

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 physician of Dr. Nesochi LLC 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 Dr. Nesochi LLC 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
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)

Please indicate your preferred Pharmacy /Pharmacies below:

Pharmacy Name: _____

Phone Number: (___) _____

Address: _____

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

Authorization to Access Electronic Prescription Records

I authorize Dr. Nesochi LLC 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 medical record.

Health Information Exchange (HIE)

Dr. Nesochi LLC also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize Dr. Nesochi LLC 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.

Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, United Health, or any other insurance plans, directly to the provider in Dr. Nesochi LLC 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 Dr. Nesochi LLC or any other holder of medical or other information about me to release to Medicare, Medicaid, United Health, 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 Dr. Nesochi LLC through its physicians, employees, and/or agents, to provide such medical care including telemedicine visits 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 physician, 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.

Appointment Cancellation Policy

If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. If Dr. Nesochi LLC does not receive notice within a 24-HOUR period, a $25.00 fee will be applied to the patient's account.

Acknowledgements and Agreements

- I acknowledge that I have been advised of my right to an Advance Directive.
- I acknowledge receipt of the 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 agree to the appointment cancellation policy
- 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 for Patient

Relationship to Patient/Authority to Sign