PATIENT REGISTRATION

Date: _____ Date of Birth: _____ Age: _____

Circle One: Male Female Marital Status: Single Married Divorced Widow

PATIENT NAME: _____ E-mail Address: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____

SOCIAL SEC #: _____ Responsible Party: _____

EMPLOYER: _____

OCCUPATION: _____

EMPLOYER'S ADDRESS: _____

CITY/STATE/ ZIP: _____

EMPLOYER'S PHONE: _____

NAME OF SPOUSE: _____

SOCIAL SECURITY #: _____

SPOUSE EMPLOYER: _____

EMPLOYER PHONE #: _____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____

MEDICAL HISTORY

Drug Allergies: _____
Current Medications: _____

List any PREVIOUS SURGERIES or MEDICAL PROBLEMS in the last 20 YEARS

FAMILY MEDICAL PROBLEMS

SOCIAL HISTORY: CHECK ANY THAT APPLY

SMOKING _____ ALCOHOL _____ OTHER DRUG USE _____

MEDICAL INSURANCE

MEDICARE#: _____ MEDICAID#: _____

COMMERCIAL INSURANCE:
ID #: _____
Insurance Company Name: _____
Insurance Company Address: _____
City/State/Zip: _____

SECONDARY INSURANCE:
ID#: _____
Insurance Company Name:
Insurance Company Address: _____
City/State/Zip: _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, South Texas Neurosurgical Associates, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that the services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that South Texas Neurosurgical Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that South Texas Neurosurgical Associates reserves the right to change their notice and practices and prior implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should South Texas Neurosurgical Associates change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____

Patient's Signature

_____

Date