BEND SURGICAL ASSOCIATES
PATIENT REGISTRATION FORM

PATIENT NAME_____BIRTHDATE_____/_____/_____
(LAST) (FIRST) (MI)

AGE_____ SS# (LAST 4 ONLY) _____ EMAIL_____

MAILING ADDRESS_____ CITY_____ STATE_____ ZIP_____

STREET ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE (_____) _____-_____ MAY WE LEAVE A DETAILED MESSAGE? YES _____ NO _____

CELL PHONE (_____) _____-_____ MAY WE LEAVE A DETAILED MESSAGE? YES _____ NO _____

EMPLOYER_____ WORK# (_____) _____-_____OCCUPATION_____

EMERGENCY CONTACT PERSON_____ PHONE (_____) _____-_____RELATIONSHIP_____

PRIMARY CARE PHYSICIAN_____REFERRING PHYSICIAN_____

PHARMACY_____PHARMACY LOCATION_____

RESPONSIBLE PARTY (IF MINOR) _____ BIRTHDATE_____/_____/_____

MAILING ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE (_____) _____-_____ RELATIONSHIP TO PATIENT_____SS#_____

PRIMARY INSURANCE CARRIER_____ID#_____GROUP#_____

NAME OF INSURED_____BIRTHDATE_____/_____/_____

SECONDARY INSURANCE CARRIER_____ID#_____GROUP#_____

NAME OF INSURED_____BIRTHDATE_____/_____/_____

******THIS SECTION REQUIRED BY CENTERS FOR MEDICARE & MEDICAID SERVICES FOR ELECTRONIC HEALTH RECORD REPORTING******

RACE (CHECK ONE)
- □ American Indian or Alaska Native
- □ Asian
- □ Native Hawaiian/Pacific Islander
- □ Black or African American
- □ White
- □ Other_____
- □ REFUSED

ETHNICITY (CHECK ONE)
- □ HISPANIC/LATINO
- □ NON-HISPANIC/NON-LATINO
- □ REFUSED

PREFERRED LANGUAGE (CHECK ONE)
- □ ENGLISH
- □ SPANISH
- □ OTHER_____

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

_____ _____
RESPONSIBLE PARTY SIGNATURE DATE

BEND SURGICAL ASSOCIATES

HIPAA Privacy Act

My Health information may include both created and received by **Bend Surgical Associates** and may be in the form of written or electronic records, or spoken words. My record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health related information.

I understand that I have the right to receive and review a written description of how Bend Surgical Associates will handle my health information. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Bend Surgical Associates and my right regarding my health information.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also, understand that a copy or summary of the most current version of Bend Surgical Associates' Notice of Privacy Practices in effect will be posted in the waiting/reception area.

By signing, I agree that I have reviewed and understand the information above and that I have been offered/received a copy of the Notice of Privacy Practices.

Patient's Signature: _____Date: _____

Special Permission Request

Initial: _____ give my permission for Bend Surgical Associates to leave messages regarding appointments on my home answering machine.

Initial: _____ I give my permission to have messages regarding treatment, billing, and/or appointment status left with my spouse/partner/caregiver: _____

Name of spouse / partner / caregiver

Initial: _____ this release will be revoked by written permission only. I understand that I must send a written request to Bend Surgical Associates in order to revoke this release.

Do you have an Advanced Health Care Directive? Yes / No

If yes, is it on file with your Primary Care Provider? Yes / No