CATAWBA VALLEY INFECTIOUS DISEASE CONSULTANTS - PATIENT REGISTRATION FORM

PATIENT INFORMATION:

DATE_____/_____/_____

NAME: LAST_____ FIRST _____ MIDDLE INITIAL _____

CIRCLE ONE: MR. MRS. MISS. MS. JR. NICKNAME OR PREVIOUS NAME: _____ (IF APPLICABLE)

MAILING ADDRESS _____

STREET ADDRESS (IF DIFFERENT FROM MAILING) _____

CITY _____ STATE _____ ZIP_____ HOME PHONE (_____) _____ - _____

CELL PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____ EXT. _____

APPOINTMENT AND HEALTH REMINDERS:

Is it okay to leave a message regarding your appointment reminder? □ Yes □ No

Phone Preferred Phone: _____

Who is your Primary Care Provider? _____

DATE OF BIRTH _____/_____/_____ **SEX** □ F □ M □Transgender **SOCIAL SECURITY #** _____ / _____ / _____

MARITAL STATUS: □ SINGLE □ DIVORCED □ LEGALLY SEPARATED □ PARTNER

□ MARRIED (SPOUSE NAME _____) □ WIDOWED

EMPLOYMENT STATUS: EMPLOYER NAME _____

ADDRESS _____

□ FULL TIME □ NOT EMPLOYED □ RETIRED □ PART TIME □ SELF EMPLOYED □ ACTIVE MILITARY □ DISABLED

STUDENT STATUS: □ FULL TIME □ PART TIME □ NOT A STUDENT

EMERGENCY CONTACT: Authorized to release medical information to Emergency Contact? □ YES □ NO

NAME: LAST_____ FIRST _____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____ EXT. _____

MOBILE/CELL PHONE: (_____) _____ - _____

INSURANCE INFORMATION: Please provide us with your insurance card so that we can scan a copy into your medical record.

RESPONSIBLE PARTY: (Responsible party is the person financially responsible for the patient statement/bills)

□ SELF □ GUARANTOR - RELATIONSHIP TO PATIENT _____(Complete below if different than "Patient Information" above)

NAME_____ ADDRESS _____

CITY_____ STATE _____ ZIP_____ HOME PHONE (_____) _____ - _____

DOB_____/_____/_____ SOCIAL SECURITY # _____ / _____ / _____ SEX □ F □ M

EMPLOYER NAME _____ ADDRESS _____

ADVANCE DIRECTIVE:

Do you have a Living Will or an Advance Directives document? Please check all that apply

□ NO □ DNR (Do Not Resuscitate) □ POA (Power of Attorney) □ Living Will

If not, our staff will be glad to provide you with information. If you have already signed a living will or advanced directive form, please submit a copy to this office for our records.

□ I wish to receive Advanced Directive Information

□ I do not wish to receive Advanced Directive Information

□ FOR CLINIC USE ONLY: Information given to Patient

Please note: If you have a medical emergency while receiving care, treatment or services at Catawba Valley Infectious Disease Consultants, life-saving actions will be started even if you have an advanced directive.

If you would like to access your Personal Health Record (PHR) online, please check yes below and provide us with your email address.

□ **YES** □ **NO** **Email Address:** _____

May we leave a message to have you return our call with family, friends, or on an answering machine at:

HOME □ YES □ NO **CELL** □ YES □ NO **WORK** □ YES □ NO

RACE: _____ ETHNICITY: □ HISPANIC □ NON-HISPANIC

INTERPRETATION SERVICES NEEDED? _____ IF SO, WHAT LANGUAGE OR SERVICE: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO: (example: spouse, child, or caregiver)

Name	Phone	Relationship to Patient

PHARMACY (RETAIL):

NAME _____

ADDRESS / LOCATION _____

PHONE (_____) _____ - _____

FAX (_____) _____ - _____

PHARMACY (MAIL ORDER):

NAME _____

ADDRESS / LOCATION _____

PHONE (_____) _____ - _____

FAX (_____) _____ - _____

MAIL ORDER UNIQUE MEMBER ID # _____

My signature below signifies that the above information is true to the best of my knowledge.

(PATIENT SIGNATURE) (DATE)

(RESPONSIBLE PARTY SIGNATURE) (RELATIONSHIP) (DATE)