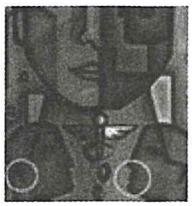

ENTRUST
MEDICAL GROUP

PATIENT REGISTRATION INFORMATION

(Please PRINT and complete all sections below)

PATIENT'S PERSONAL INFORMATION

Name: _____ Sex: M ❑ F ❑ Age: _____ Date of Birth: _____
First MI Last

Address: _____ City _____ State _____ Zip _____

Social Security # _____ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Preferred Method of Contact:

Home Phone (_____) _____ Approval to leave message? ❑ Y ❑ N

Cell Phone (_____) _____ Approval to leave message? ❑ Y ❑ N

Email Address _____ Approval to leave message? ❑ Y ❑ N

**Can we reach you by email for appointment reminders / reschedule? ❑ Yes ❑ No

Work Phone: (_____) _____ Approval to leave message? ❑ Y ❑ N

Employer: _____ Occupation: _____

Work Address: _____ City _____ State _____ Zip _____

PRIMARY CARE PHYSICIAN: _____ Phone (_____) _____

Which physician referred you to us? _____ Other: _____

EMERGENCY CONTACT: _____ Phone (_____) _____
Name and Relationship

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Name of Financially Responsible Person: _____

Address: _____ City _____ State _____ Zip _____

Relationship to Patient: _____ Social Security # _____ Date of Birth: _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Employer: _____ Occupation: _____

SPOUSE NAME: _____ Date of Birth: _____

Spouse Employer: _____ Spouse Occupation: _____

**Preferred method of contact: ❑ Cell ❑ Home ❑ Work Approval to leave message or email? ❑ Y ❑ N

PATIENT'S INSURANCE INFORMATION AND ELIGIBILITY GUARANTEE

PRIMARY INSURANCE COMPANY

Insurance Company Name: _____ Name of Insured Person: _____

Insured Date of Birth: _____ Insured Social Security # _____

SECONDARY INSURANCE COMPANY

Insurance Company Name: _____ Name of Insured Person: _____

Insured Date of Birth: _____ Insured Social Security # _____

I, THE UNDERSIGNED, REALIZE THAT ALL MEDICAL AND SURGICAL CHARGES INCURRED ARE MY FINANCIAL RESPONSIBILITY AND PAYABLE BY ME. I UNDERSTAND THE OFFICE WILL DO ITS BEST TO BILL ANY INSURANCE THAT I MAY HAVE, BUT I AM STILL ULTIMATELY RESPONSIBLE FOR THE CHARGES. I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER TO PAY DIRECTLY TO ENTRUST MEDICAL GROUP ANY BENEFITS DUE TO ME AND UNDER MY INSURANCE PLAN, INCLUDING DEDUCTIBLES AND CO-PAYMENTS. I AUTHORIZE RELEASE OF INFORMATION FROM MY MEDICAL RECORD REQUIRED FOR TREATMENT OR BILLING PURPOSES.

_____ _____
AUTHORIZED SIGNATURE DATE

ENTRUST
MEDICAL GROUP

Acknowledgement of Receipt of Notice of Privacy Practices

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices***. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. I acknowledge receipt of the ***Notice of Privacy Practices***.

Signature:		Date:
Print Name:		Date:

If not signed by the patient, please indicate who signed:

□ Parent or guardian of minor patient
□ Guardian or conservator of an incompetent patient
□ Beneficiary or personal representative of deceased patient

Name of Patient:_____

Confidential Contact Information

- If it becomes necessary to contact you by phone, do we have your permission to leave messages on your answering machine or voicemail? □ Yes or □ No
- What is the best time of day to reach you? _____
- Where do you prefer to receive our call? □ Home phone/ □ Work phone/ □ Cell phone

Disclosure of Confidential Health Information

I agree that ENTRUST Medical group, may disclose/discuss my health information with the following persons listed below as persons involved with my healthcare. I understand that I am not required to list anyone. I also understand that I may change this list at any time.

Name/Relationship _____ Phone_____

Name/Relationship _____ Phone_____

Name/Relationship _____ Phone_____

For office use only: Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: Date:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please Specify) _____