Block Island Medical Center
PATIENT REGISTRATION

Date: _____

PATIENT INFORMATION

Patient Name:_____**Preferred Name:**_____
Last Name First Name MI

Gender: ___ Male ___ Female **D.O.B.:** _____ **SSN#:** _____- _____ - _____

Mailing Address: _____ City: _____ State: _____ Zip Code:_____

Home phone #: _____ - _____ - _____ **Cell phone #:** _____ - _____ - _____ **Work phone #:** _____-_____- ____

Email: _____**Preferred contact method?**_____

Consent to receive automated phone/text/email message reminders: Yes _____ **No**_____

Primary Language: ___ English ___ Spanish ___ French ___ Portuguese Other _____

Race: ___ Native American or Alaskan ___ Asian ___ Black or African American ___ White ___ Decline to specify

Ethnicity: ___ Hispanic ___ Non Hispanic ___ Decline to specify

Marital Status:
___ Single ___ Married ___ Legally Separated ___ Divorced ___ Widowed ___ Domestic Partner

GUARDIAN/EMERGENCY CONTACT INFORMATION

Emergency Contact: _____**Relationship:** _____

Home phone #: _____ - _____ - _____ **Cell phone #:** _____ - _____ - _____

Responsible Party: (Please indicate relationship to patient)_____

EMPLOYER INFORMATION

Employer Name: _____ **Employer Phone:** _____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Provider: _____
Last Name First Name

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone #: _____ - _____ - _____ Fax #: _____ - _____ - _____

Preferred Pharmacy_____

PLEASE SEE REVERSE SIDE

INSURANCE

Please Present Your Insurance Card and ID to the Receptionist

Primary Insurance Company: _____

Secondary Insurance Company: _____

Assignment of Benefits:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Primary Insurance Company
and assign directly to Block Island Health Services Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____

HIPAA Privacy and Release of Information Authorization

I hereby authorize BIHS, Inc. and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives signing below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Signature: _____ Date: _____

Please Initial each item: _____ I have read the BIHS Practice Privacy statement.

_____ I have read the BIHS Patient Bill of Rights