

ESSEX INTERNAL MEDICINE - REGISTRATION FORM

Today's Date ____/____/____

PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (Circle One)
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid

Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Street Address	City	State	ZIP Code	Social Security	Home Phone No. ()
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P.O. Box	City	State	ZIP Code
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Occupation	Employer	Employer Phone No. ()
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Chose Doctor because recommended by (Please check one box) Dr. _____ Insurance Plan Hospital

Family Friend Close to Home/Work Yellow Pages Other _____

Name of Spouse (if applicable) _____ MY EMAIL ADDRESS: _____

- Check all that apply. I consider myself to be of a race other than white (Caucasian). Please specify _____
- At home we mostly speak a language other than English. Please specify _____
- I consider myself to be of Hispanic or Latino descent

(The purpose of these questions is so that we can use our electronic records system to detect and correct racial and ethnic differences in the quality of care, e.g. immunization rates. You are not required to complete this section but doing so helps us to continuously improve.)

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ()
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Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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Occupation	Employer	Employer Address	Employer Phone No. ()
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Is this patient covered by insurance? Yes No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
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Patient's Relationship to Subscriber Self Spouse Child Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #
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Patient's Relationship to Subscriber Self Spouse Child Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this office or my insurance company(s) to release any information required to process my claims.

X _____
PATIENT/GUARDIAN SIGNATURE
DATE

ESSEX INTERNAL MEDICINE
Drs Baldwin, Hornbake and Spagnola PC
10 Wildwood Medical Center
Essex CT, 06426

Phone: 860-767-0145

Fax: 860-767-0021

AUTHORIZATION TO SHARE MEDICAL INFORMATION

Connecticut state law requires that you consent to most medical treatments for yourself. Federal statutes prohibit the release of information to others without your specific written consent except in emergency situations.

If you wish an adult other than yourself or legal guardian to participate in medical decision making or to receive reports about your condition your specific consent is required. If this is your desire please complete the information below.

I, _____ authorize the following individual(s) to have access to my medical information.

Name _____

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Name _____

—

Name _____

—

Name _____

—

Patient
Signature: _____

Date
Signed: _____