HUNTERDON FAMILY PHYSICIANS

PATIENT REGISTRATION FORM

Last Name: _____ **First Name**: _____ **MI**: _____

Birth Date: _____ **Email Address**:_____ **Marital Status:** M S W D

Mailing Address: _____ **City**: _____

State: _____ **Zip Code**:_____ **Sex:** Male Female **Employer**:_____

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐White ☐Hawaiian/Pacific Island Native

Ethnicity: ☐Hispanic/Latino ☐Non Hispanic/Latino **Preferred Language:** ☐English ☐Spanish

Phone Numbers:

Home_____ *May we leave messages here:* YES NO

Cell_____ *May we leave messages here:* YES NO

Work_____ *May we leave messages here:* YES NO

*I authorize HFP to release my medical information, whether verbally or in writing, to the following person(s). *Medical information includes, but is not limited to, records/forms, prescriptions, referrals, and test orders/results.*

1. **Name:**_____ Relationship: _____
2. **Name:**_____ Relationship: _____

Emergency Contact Information *(we will not release information to your emergency contact unless there is an emergency or their name is listed above).*

Name: _____ Relation to Patient: _____

Phone: Home_____ Cell_____

Do you or the patient have an Advanced Directive (Living Will)? YES NO
(please ask our front desk staff if you would like more information)

CONSENT TO TREAT

I certify that all information provided is true to the best of my knowledge. I, the undersigned (patient or legal guardian), authorize medical or surgical treatment to be rendered by Hunterdon Family Physicians. I understand that payment is due at the time of service, that there will be a charge for all returned checks, a finance charge of 1.5% per month for all late payments, and that I will be responsible for all costs incurred as a result of the delinquency of my account. I also grant HFP permission to release my information to insurance company for claim filing purpose.

ELECTRONIC HEALTH INFORMATION SHARING SYSTEM

Our practice uses an electronic information sharing system that shares health information among physicians and practices who are in the care of mutual patients in the Hunterdon County area. As our patient, you automatically opt-in to the system. If you would like to opt-out, please see our front desk staff.

By signing, I acknowledge all information is true and I agree to all terms on this Registration Form.

Patient/Guardian Signature: _____

Print Name: _____ **Date:** _____