



## Patient Registration Form

### Personal Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell / Alt. Phone # \_\_\_\_\_ Email \_\_\_\_\_

Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Driver's Lic. \_\_\_\_\_ State \_\_\_\_\_

Sex  Male  Female

Marital Status  S  M  W  D

### Medical Insurance Information

**Primary Insurance** \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Subscr. DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscr. Employer \_\_\_\_\_ Subscr. SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Employer's Address/Phone \_\_\_\_\_

Member/Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Subscriber's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Employer's Address/Phone \_\_\_\_\_

Member/Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Medicaid #** \_\_\_\_\_ **Medicare #** \_\_\_\_\_

### Pharmacy Information

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

#### Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to NorthStar Surgery Specialists, P.A. for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

\_\_\_\_\_  
Patient, Parent or Guardian Signature (if child is under 18 years old)

\_\_\_\_\_  
Date



12414 Alderbrook Drive  
Suite 101  
Austin, TX 78758  
Phone: (512) 491-6542  
Fax: (512) 491-0161

### Additional Contact Information

1. **In case of an emergency**, please list a family member or significant other, if any, whom we may inform about your medical condition:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2. Please print the address and phone number of where you would like correspondence from our office to be sent if other than your home address and phone. This could include health information such as appointments, lab results, X-ray results, or other information:

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

3. Can confidential messages be left on your:

Home telephone answering machine:     Yes     No  
Cell phone voicemail:                       Yes     No  
Work voicemail:                                 Yes     No

4. Do you have a LIVING WILL?     Yes     No

5. Do you have a Medical POWER OF ATTORNEY?     Yes     No

If yes, Name \_\_\_\_\_ Number \_\_\_\_\_

#### Acknowledgement of Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices of NorthStar Surgery Specialists, P.A., which explains in plain language how my protected health information (PHI) will be used and disclosed, my individual rights, and the practice's legal duties with respect to my PHI. I understand that I am entitled to receive a copy of this information upon request.

Signature \_\_\_\_\_ Date \_\_\_\_\_