**Registration Form**

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| **Patient Information**  **Patient Name: .**  First Middle Initial Last  **Sex:**  Male  Female **Date of Birth: / / .**  MM DD YYYY  **Race:**  Asian  White  Black or African American  Other Race  Unreported / Refused to report  **Ethnicity:**  Hispanic or Latin  Not Hispanic or Latin  Refused to Report  **Language:** **Social Security# .**  **Address: .**  Street # Street Name Apt #  .  City State Zip  **Home Phone:**  **Mom’s Work Phone: Mom’s Cell: .**  **Dad’s Work Phone: Dad’s Cell: .**  **Email Address: .**  **Mother's Name: DOB: .**  **Father's Name: DOB: .**  **Emergency Contact Name: Relation: .**  **Phone #1: Phone #2: .**  **Referred By: Primary Care Physician: .**  **Insurance Information**  **Primary Insurance Name: Name of Policy Holder: .**  **Patient’s ID # Date of Birth: .**  **Group # Relationship to Patient: .**  **Effective Date: Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**  **Address: City/ State/Zip .**  **Home Phone ( ) Cell Phone ( ) .**  **Employer Name: Work Phone ( ) .**  **Secondary Insurance Name: Name of Policy Holder: .**  **Patient’s ID # Date of Birth: .**  **Group # Relationship to Patient: .**  **Effective Date: Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**  **Address: City/State/Zip .**  **Home Phone ( ) Cell Phone ( ) .**    **Employer Name: Work Phone ( ) .**    **Pharmacy Information**  **Name #1: Name #2: .**  **Address: Address: .**  **Phone ( ) Phone ( ) .**  **Authorization to Release Health Information**  I hereby authorize Jae Hong Min, M.D.,P.C. to use and disclose protected health information (PHI) about me to government agencies, insurance companies, or others who are financially liable for my medical care, as necessary, for the purposes of obtaining medical treatment.  **Receipt of the Notice of Privacy Practices**  By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices on the date indicated below and Jae Hong Min, M.D.,P.C. reserves the right to change its Notice of Privacy Practices, if necessary, at any time.  **Financial Agreement**  I hereby authorize that my insurance benefits be paid directly to Jae Hong Min, M.D., P.C. and acknowledge that I am financially responsible for all co-pays at the time of service and any balance not covered by my insurance.  A photocopy of this signature is as valid as the original.      .  **Print name (Parents/Guardian) Signature Date** |