Patient Registration

Your insurance card and photo id are required at the time of your visit.

Last Name: ___________________________________ First Name: _________________________________ MI: _________

DOB: ___________________________ (mm/dd/yyyy) Sex: ____________ SS#: _________ - ________ - __________

Address: ______________________________________ Apt: ______ City: _______________ State: _______ Zip: ________

Home Phone: __________________________Cell:_________________________ Work:_____________________________

Email: ____

Race: American Indian, Asian, Black, Hawaiian, Hispanic, White Ethnicity: Hispanic or Latino Y or N

Responsible Party

Name: _____________________________ Relation: ______________Address: ____________________________________

City: _____________________________________ State: __________ Zip: __________ Phone: _______________________

Where do you want the bill to be sent: _____My Address ______Responsible Party Address

Emergency Contact Information

Contact First Name: _______________________________________ Contact Last Name: ____________________________

Contact Phone: ____ Contact DOB: __________________

Relationship to Patient: _________________________ Address: ____

City: ____ State: ________________________________ Zip: ______________

How did you find us? ____

Other Family Seen Here

Name: ____ Relationship to Patient: ______________________________

Name: ____ Relationship to Patient: ______________________________

Primary Care/Other Physician

Physician Name: ______________________________ Practice Name: ____

Address: ____ City: ___________________ State: ________ Zip: __________

<u>Authorization to release or use information for treatment, payment, or health care operations</u>

I hereby authorize the release or use of my individually identifiable health information (Protected Health Information or PHI) and medical information by Classen Urgent Care Clinic / Classen Family Medicine in order to carry out treatment, payment or health care operations. You should review the our Notice of Privacy Practices for a more complete description of the potential release and use of such information. You have the right to review such Notice prior to signing this Consent Form – it is available from our front desk staff. We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your PHI is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

By signing below, I attest that the information provided above is true and accurate.

Authorization to release information to a family member/friend.

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to your PHI. By completing this form, you are informing us of your wish to designate the named person as your personal representative with respect to uses and disclosures of your PHI.

I, _____________________________________(printed name and date of birth), hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my PHI.

____(*Printed Name of Personal Representative)*

The authority of this person, when acting as my personal representative, is restricted to the following functions:

This person is to be afforded all of the privileges that would be afforded to me with respect to my Protected Health Information.

I acknowledge and understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Classen Urgent Care Clinic and/or Classen Family Medicine 2824 Classen Blvd., Norman, OK 73071. I further acknowledge and understand that any revocation does not apply to the extent that persons authorized to use or disclose my Protected Health Information have already acted in reliance on this designation.

By signing below, I consent to be treated at CUCC and/or CFM. I attest that the information given is accurate to the best of my knowledge. I have been given access to a copy of the Notice of Privacy Practices, Financial Responsibilities and Ownership Disclosure. I understand and agree to the terms.

Signature of Patient/Guardian: ____ Date: _________________

Insurance Information

Reason for Being Seen Today: ____

Primary Insurance

Insurance Company: ____

Policy Holder Name: ____

Social Security #: ________ - ______ - _________ DOB: _____________ Relationship to Patient: _____________

Address: _________________________________ City: ________________ State: _______ Zip: ______________

Phone #: ____________________ Ext: ________ ☐ Same as mine ☐ Same as Responsible Party

Insured Employed by: ________________________________ Business Address: ____________________________

City: _________________________ State: ____________ Zip: _____________

Business Phone #: __________________________

Secondary Insurance

Insurance Company: ____

Policy Holder Name: ____

Social Security #: ________ - ______ - _________ DOB: _____________ Relationship to Patient: _____________

Address: _________________________________ City: _________________ State: _______ Zip: ______________

Phone #: ____________________ Ext: ________ ☐ Same as mine ☐ Same as Responsible Party

Insured Employed by: ________________________________ Business Address: ____________________________

City: ____________________________ State: ____________ Zip: _____________

Business Phone #: __________________________

Employment Status

☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

Business Name: ______________________________________ Business Phone: ____________________________

Is this an on the job accident? ☐ Yes ☐ No

Date of Injury ________________

Is this a motor vehicle accident? ☐ Yes ☐ No

By signing below, I attest that the information provided above is true and accurate,

Signature of Insured/Guardian: ____ **Date:** __________________

I agree and consent to releasing information to me in the following manners:

		PLEASE INITIAL
Via Mail		
Ok to mail to home address	☐	__________
Via Home Telephone		
Ok to leave detailed message	☐	__________
Via Work Telephone		
Ok to leave detailed message	☐	__________
Via Email		
Ok to email	☐	__________
Via Texts		
Ok to text for appointment reminders if applicable.	☐	__________

Any restrictions on the type of information? ____