Optimum Health/David Miloy MD PA

PATIENT REGISTRATION FORM

Social Security #:_____-____-_____ Date of Birth: _____/_____/_____ Sex: Male/ Female

Last Name: _____ Middle Initial: _____First Name: _____

Street Address: _____

City/State/Zip: _____

Home Phone #:_____Cell #:_____

Email Address:_____ (
You will receive an invitation to register for our secure online portal via email)

Patient's Employer: _____Work #:_____

Employer's Address: _____ Occupation: _____

City: _____State/Zip: _____

Marital Status (circle one): Single, Married, Widowed, Separated, Divorced, Other

Spouse's Name: _____

If you have Medicare, are you or your spouse currently working? (circle one) Yes No Primary Insurance Information:

Name of Insurance: _____

Name of Subscriber: _____SS#:_____-_____-_____

DOB of Subscriber: _____/_____/_____Subscriber's Employer:_____

Subscriber's Employer's Address: _____

Secondary Insurance Information:

Name of Insurance: _____

Name of Subscriber: _____SS#:_____-_____-_____

DOB of Subscriber: _____/_____/_____Subscriber's Employer: _____

Subscriber's Employer's Address: _____

First Emergency Contact:
Name:
_____Phone#:_____Relationship:_____
_

Second Emergency Contact:
Name:
_____Phone#:_____Relationship:_____
_

Ethnicity (circle one): Hispanic, Non-Hispanic, Patient Declines

Race (circle one): American Indian, Asian, Black or African American,

Native Hawaiian or other Pacific Islander, White, Patient Declines

Preferred Language (circle one): English, Spanish, Other_____

Preferred method of communication for follow up care (circle one): Phone, Mail, Patient Portal

How will you be paying today? (circle one) Cash, Check, Visa, MasterCard,

It is the policy of Optimum Health/ David Miloy MD PA. to communicate only with the patient using the contact information provided by the patient. HIPAA of 1996 establishes the right for patients to request alternative methods of communication from our office. If there is anyone, other than yourself, that you would like us to release information to, please list them below. Please note that we will not be able to communicate with anyone other than you without your written permission.

Name:
_____Relationship:_____

Name:
_____Relationship:_____

(Circle one or both) Medical Info / Billing Info.

If this request changes you are responsible for notifying GIM.

I AUTHORIZE THE PHYSICIAN IN CHARGE TO ADMINISTER MEDICAL CARE AS IS NECESSARY. OPTIMUM HEALTH/ DAVID MILOY MD PA WILL FILE YOUR INSURANCE AT THE TIME OF SERVICE. IF YOUR INSURANCE REQUIRES THAT YOU PAY A DEDUCTIBLE OR CO-INSURANCE YOU ARE RESPONSIBLE FOR PAYING THAT AT THE TIME OF SERVICE. IF YOU HAVE NO INSURANCE YOU WILL BE REQUIRED TO PAY IN FULL AT THE TIME OF SERVICE. WE WILL ACCEPT CASH, CREDIT CARD OR PERSONAL CHECKS.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR CHARGES INCURRED AT GARNER INTERNAL MEDICINE REGARDLESS OF THIRD PARTY LIABILITY. I AGREE THAT OPTIMUM HEALTH/ DAVID MILOY MD PA MAY RELEASE ANY MEDICAL INFORMATION NECESSARY FOR FILING MY CLAIM.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION IN POSSESSION OF OPTIMUM HEALTH/ DAVID MILOY MD PA TO ANY CONSULTING MEDICAL PERSONNEL FOR THE PURPOSE OF RENDERING TREATMENT OR TO CONTINUE MY CARE.

Patient's Signature: _____Date:_____

Signature of Personal Representative: _____Date:_____