TRIANGLE FAMILY MEDICINE

NEW PATIENT REGISTRATION

(Please Print)

PATIENT INFORMATION			
Last name:	First name:	Middle name:	
Mailing address:	City:	State:	ZIP code:
Home phone number:	Cell phone number:	Work phone number:	
Date of birth:	Sex:	Marital Status: circle one Single Married Divorced Separated Widowed	
Sex assigned at birth: circle one Male Female	Sexual Orientation:	Preferred Pronouns:	Social Security Number:
Student status: circle one Full-time Part-time Not a student		Employment Status: circle one Full-time Part-time Not employed Retired	
Employer name:	Employer address:		
If patient is a minor, give parent/guardian names and specify relation to the patient:			
Email:	Are you interested in signing up for our patient portal? YES NO		

EMERGENCY CONTACT INFORMATION			
Name:	Relationship to patient:	Home phone number:	Cell phone number:
Mailing address:	City:	State:	ZIP code:

INSURANCE INFORMATION		
Name of primary insurance:	Policy subscriber's name, if not the patient:	Policy subscriber's date of birth:
Patient's relationship to subscriber:		
Name of secondary insurance (if applicable)	Policy subscriber's name, if not the patient:	Policy subscriber's date of birth:
Patient's relationship to subscriber:		

OTHER INFORMATION	
Pharmacy name:	Pharmacy phone number:
Pharmacy address:	
How did you hear about us, or who referred you here?	

RESPONSIBLE PARTY (GUARANTOR)			
The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip this section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.			
Guarantor's last name:	Guarantor's first name:	Guarantor's middle name:	
Guarantor's mailing address, if different from patient:	City:	State:	ZIP code:
Guarantor's phone number:	Relationship to patient:	Guarantor's date of birth:	Guarantor's Social Security Number:

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Financial Policy, Assignment Information, and Release of Information

I authorize Triangle Family Medicine to release any information about me that may be necessary to complete and file medical claims; necessary for treatment (i.e. to send protected health information to a referring physician); or necessary to communicate with me.

I hereby acknowledge financial responsibility for costs of services rendered for me or for the person for whose account I am acting as guarantor. I am familiar with the policies, procedures and benefits of my insurance plan and I request medical services at this office. I am responsible to inform Triangle Family Medicine of any changes in insurance status prior to services being rendered. I am responsible for any non-covered services, supplies, copayments or deductibles. I authorize (assign) any insurance or Medicare benefits to be paid directly to Triangle Family Medicine, PA or its assignees. **All co-payments and/or payments are expected in full at the time of service.**

Triangle Family Medicine requests that you provide 24 hour notice to cancel or reschedule your appointment. **Please note a $25 fee will be charged when an appointment is missed without advance notice.** Triangle Family Medicine reserves the right to dismiss from the practice any patients who frequently miss scheduled appointments. This acceptance and assignment will be in force for all future services by practitioners from this office.

Scheduling

When making your appointment please be specific about your health care concern to ensure that adequate time is allowed. Annual checkups are intended to be a preventive health exam. All other acute, urgent, and chronic problems will require separate appointments. Annual checkups do not include GYN/PAP exam – they also require a separate appointment.

Forms

You are required to bring forms (such as sports physical, camp, school, work) to your scheduled appointment. There will be a charge of $15 for forms provided at a later date

Referrals

Referral requests usually require one week to be processed. You may need an appointment if the referral is to a specialist or for a new problem.

Prescription Refills

Please ask your pharmacy to fax us a refill request. Please allow 2 business days to process your request. An office visit is required if it has been more than 6 months since your last visit and for any new medicines.

Acknowledgement of HIPAA Notice of Privacy Practices

We are required to provide you with our Notice of Privacy Practices. By signing below, I acknowledge that I have had the opportunity to review the HIPAA Notice of Privacy Practices of Triangle Family Medicine. I understand that I can request an additional written copy of this Notice at any time.

May we leave appointment reminders on your voicemail? YES NO

Do you authorize us to disclose your confidential health information with someone you designate? YES NO
If yes, please list their name(s) and phone number(s) below

_____

_____ _____
Signature of Patient or Patient's Guardian/Representative Date

_____
Printed Name of Person Signing Above