HONORHEALTH

Medical Group

New Patient Registration – Demographics and Insurance

Patient: Name/First _____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Patient street address: _____

Patient address additional: _____

City: _____ State: _____ ZIP: _____-_____

Primary Phone Number: (_____) _____-_____Mobile | Home | Work

Secondary Phone Number: (_____) _____-_____Mobile | Home | Work

Email address: _____

What is your primary language? _____ Interpreter Required? Yes | No

Marital Status: Divorced | Legally Separated | Married | Other | Sig. Other | Single | Widowed

Religious preference: _____ ☐ I prefer to not answer.

The U. S. government requires we ask the following two questions:

1. How do you identify your ethnicity?
   _____Hispanic or Latino _____ Not Hispanic or Latino
   _____ I prefer to not answer.

2. How do you identify your race?
   _____ American Indian or Alaska Native _____ Black or African American
   _____ Native Hawaiian _____ Other Pacific Islander
   _____ White or Caucasian _____ Asian
   _____ I prefer to not answer

Who is your primary care physician? _____

Name of the primary care practice: _____

Employment Status: Full-Time | Part-Time | Retired | Disabled | Student | Unemployed

Employer Name: _____

How many employees work at your company? ☐ 1-19 ☐ 20-99 ☐100+ ☐ Don't know

Patient Name: First_____ Middle_____ Last_____ Date of Birth: ____/_____/_____

Who would you like to list as an **emergency contact**?

Name: _____

Address: _____

_____

Relationship to you: _____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Who is the **guarantor** of your account? Who is financially responsible for any amount not paid by the insurance company? Please write "self" if you are financially responsible.

Guarantor: Name/ First_____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Address: _____

_____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Medical Insurance Company Name: _____

Member/Subscriber Identification #: _____ Group #: _____

Medical Insurance Company Address: _____

Relationship of the insurance subscriber to the patient: Self | Parent | Spouse | Other: _____

Subscriber: Name/ First_____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Address: _____

_____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Do you have any additional insurance? Yes | No
Please present all insurance cards.

Authorization to Use or Disclose Protected Health Information

HonorHealth Facility:

_____

_____

_____

- ❑ **For Thompson Peak Hospital requests, please mail your requests to the Shea Campus**
- ❑ **For Sonoran Health and Emergency Center requests, please mail your requests to the Deer Valley Campus**

PATIENT IDENTIFYING INFORMATION:

Patient Full Name: _____ Date of Birth: _____
Patient Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____
E-Mail Address: _____

Release Information To: ☐ Hold for Patient Pick-up ☐ Mail Copies To:
I hereby authorize HonorHealth to release my medical record information to:

Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____
Purpose of Request: ☐ Personal ☐ Continuing Care ☐ Legal ☐ Other: _____

Specific Information to be Released:

Date(s) of Service: _____

☐ Pertinent Information* (includes H & P, discharge and other dictated reports, EKG, labs and radiology)
☐ Discharge Summary ☐ History & Physical ☐ Operative Report ☐ ER Report ☐ Consultation Report
☐ EKG ☐ Diagnostic Imaging Reports ☐ EEG ☐ Lab Results ☐ Pathology Reports
☐ Diagnostic Films (specify): _____ ☐ Complete Records: Date of Visit _____
☐ Other (specify): _____
☐ Family Practice Clinic (Request should mailed directly to the clinic)

I authorize the provider to use or disclose information related to: ☐ AIDS/HIV and other Communicable Diseases
☐ Genetic Testing Information ☐ Psychiatric Care Reports ☐ Alcohol and/or Drug Abuse Treatment

I understand that HonorHealth will not condition treatment on my signing this authorization. HonorHealth will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read HonorHealth's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to HonorHealth. Unless I *revoke* the authorization earlier, it will expire upon its completion or *60 days* from date of signature, whichever comes first. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be *re-disclosed* by the person or organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient or Description or Authority to Act for Patient

Barcode: DTHIMAUTH

For Official Use Only: (Rev 02/05/2015)
Acct#:_____Delivery Method: _____
Initials: _____Date:_____ Time: _____