PATIENT REGISTRATION

Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other: _____ **Gender:** ☐Male ☐Female

Last Name: _____ **First:** _____ **M.I.** _____

Social Security Number: _____-_____-_____ **Date of Birth:** _____/_____/_____

Local Address: _____**Apartment #:** _____ **City:** _____

Zip: _____ **Local Phone #:**(_____)_____-_____ **Cell Phone #:**(_____)_____-_____

Up North Address: _____ **City:** _____ **State:** ___ **Zip:** _____

Up North Phone #:(_____)_____-_____ **Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐Divorced

Preferred Language: ☐ English ☐ Other **Race:** _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Preferred Pharmacy Name: _____**Phone**: _____ **City or Zip code:** _____

Who is your referring Dermatologist? _____

Who is your Cardiologist? _____

Who is your Internist/Primary Care Physician? _____

Would you like access to your electronic medial records? ☐ Yes ☐ No

Email address: _____

Please read the following paragraphs and sign below.
If you have any questions regarding your insurance please ask to speak to the billing department.

I authorize the release of all medical information to all my insurance carriers, other third party payors, including assignment for Medicare or its agents, or the Social Security Administration as required or requested for the process of claims for insurance, social security, disability, or for any other insurance purposes. I authorized this office to submit to my supplement insurance if I have provided them with the appropriate card and address.
I acknowledge that if my health insurance will not allow direct payment to this office for medical care that I received, I agree to forward all health care benefits that I personally receive to this office immediately upon receipt. I acknowledge that I am responsible for all charges provided to me, including any amounts not covered by my health insurance, secondary insurance to Medicare or any other health service plan.

Patient Signature: _____ **Date:** _____

I hereby acknowledge that I was provided with a copy of this practice's Notice of Privacy Practices, and I authorize this office to use and disclose my health information for treatment, payment and for healthcare operations. Copies of the Notice of Privacy Practices are located at the check-in counter.

Patient Signature: _____ **Date:** _____

PATIENT REGISTRATION

Jeffrey Marcus, M.D., M.P.H., P.A.

Patient Consent For Use and Disclosure of Protected Health Information

1. With my consent, ***Jeffery Marcus, MD***., may use the following methods to communicate with me: **Call** my home or other designated locations and leave a message on a voice mail, send **mail** to my home or other designated locations or send **emails** to my email address or other designated email addresses.

2. I authorize ***Jeffrey Marcus, MD*** to communicate with authorized healthcare providers involved with my care about any aspect of my health and medical care by email and/or fax. This authorization for communication by means of email and/or fax is valid until I notify you in writing that I no longer authorize the use of email and/or faxes to communicate information concerning my health care. I understand that information communicated by email and/or fax will be incorporated and retained in my legal medical record. ***Jeffrey Marcus, MD*** retains the right to terminate email as a communication option if it becomes unduly burdensome or is used inappropriately.

Patient Signature:_____ Date:_____

May we discuss your medical information with another family member and/or spouse?
Yes or No

If yes, Name _____

Relationship_____

Patient Signature: _____ Date:_____

Do you have a power of attorney and/or healthcare surrogate?

YES or NO

What is the name of the POA/healthcare surrogate and relationship?

Name: _____Relationship: _____
Phone #:_____
If yes, please provide us with a copy of the documentation.