accesshealth

Patient Registration Form

Patient Information

First Name	Last Name	M.I.	Previous Name (if applicable)
Mailing Address		Apt Number	
City/State/Zip			
Home Phone	Cell Phone	Work Phone	
Preferred Method of Contact **(Please Select Only One Option)** ☐ **Voice** ☐ **Text**	If voice, please select preferred number for contact ☐ **Home** ☐ **Cell** ☐ **Work**	If voice, would you be okay with patient information in voicemail? ☐ **Yes** ☐ **No**	
Sex (Biological Gender) ☐ **M** ☐ **F**	Date of Birth	Family Physician or Pediatrician	
Marital Status	Employer Name	Social Security Number	
Emergency Contact Name	Relationship to Patient	Emergency Contact Phone Number	

Additional Information Please fill out all sections below

Email Address	Can we leave a message regarding your medical care and test results? ☐ **Yes** ☐ **No**

Race (please select one or multiple)

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Unreported/Chose not to Disclose
- ☐ More than one race

Ethnicity (please select one)

- ☐ Chicano
- ☐ Cuban
- ☐ Hispanic, Latino/a, or Spanish origin combined
- ☐ Mexican
- ☐ Mexican American
- ☐ Other Hispanic, Latino/a, or Spanish Origin
- ☐ Puerto Rican
- ☐ Spaniard
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Decline to Specify

Preferred Language (please select one) ☐ English ☐ Spanish ☐ Hindi or Urdu ☐ Sign Language ☐ Vietnamese ☐ Mandarin or Cantonese ☐ Other ____________

Preferred Pharmacy Name and Location

Responsible Party If the patient is a minor (under the age of 18) the parent or guardian bringing the patient in will be listed as the guarantor.

First Name		Last Name
Date of Birth	Social Security Number	Phone
Address of Person Responsible		Apt Number
City/State/Zip		Relationship to Patient

Primary Medical Insurance	**Secondary Medical Insurance**
Insurance Company Name	Insurance Company Name
Policy Holder Name	Policy Holder Name
Policy Holder Member ID	Policy Holder Member ID
Policy Holder's Date of Birth	Policy Holder's Date of Birth
Policy Holder's Social Security Number	Policy Holder's Social Security Number
Patient Relationship to Policy Holder	Patient Relationship to Policy Holder

I certify that I have read and agree to AccessHealth's payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to AccessHealth all money to which I am entitled for medical expenses related to the services performed from time to time by AccessHealth, but not to exceed my indebtedness to AccessHealth. I authorize AccessHealth to release any medical information to my insurance carrier or third party payer to facilitate processing of my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. I choose to receive communications from AccessHealth by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to AccessHealth. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT/GUARANTOR SIGNATURE	**PRINTED NAME**	**DATE**

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