# University Hospitals Medical Group
# PATIENT REGISTRATION

Patient Name _____ Maiden Name _____

Address _____ Home Phone _____

City / State / Zip _____ Work Phone _____

DOB _____ Age _____ Sex _____ Social Security # _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Emergency Contact _____ Relationship _____

Address _____ City / State / Zip _____

Home Phone _____ Work Phone _____

***Primary Care Physician*** _____ Office Phone _____

***Referring Physician*** _____ Office Phone _____

## Guarantor Information

Guarantor's Name (if different than patient) _____

Address _____ City / State / Zip _____

Home Phone _____ DOB _____ Sex _____ Social Security # _____

Employer's Address _____ Work Phone _____

City / State / Zip _____

## Guarantor's Employment Information

Employer _____ Office Phone _____

Address _____ City / State / Zip _____

## Primary Insurance

Company Name _____ Office Phone _____

Address _____ Certificate # _____

City / State / Zip _____ Group # _____

Effective date of insurance _____ ☐ Medicare A ☐ Medicare B

## Secondary Insurance

Company Name _____ Office Phone _____

Address _____ Certificate # _____

City / State / Zip _____ Group # _____

Effective date of insurance _____ ☐ Medicare A ☐ Medicare B

**Date Collected** _____ / _____ / _____

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# REVIEW OF SYSTEMS

Name: _____ MRN: _____ Date: _____

Review of Systems: Past or Current

| System | Examples | Y | N |
|---|---|---|---|
| General Symptoms | Fatigue, Fever, Weight Loss | | |
| Skin | Skin disease, Eczema, Psoriasis | | |
| Musculo-skeletal | Arthritis, Amputation | | |
| Gastrointestinal | Nausea, Vomiting, Diarrhea, Ulcers | | |
| Endocrine | Diabetes, Thyroid, Pituitary | | |
| Respiratory | Shortness of breath, Asthma, COPD, Allergies | | |
| Cardiovascular | Chest pain, MI, Angina | | |
| Genito-urinary | Painful urination, Poor control of urination, Hysterectomy | | |
| Neurological | Development delay, Seizures, Numbness | | |
| Hematology/Lymph | Bleeding abnormalities, Swollen Glands, Cancer, Leukemia, Mastectomy | | |
| Psychological | Confusion, Disorientation | | |

Explanation of Positive Findings: _____

_____

_____

_____

_____

_____

_____

Tech Initials: _____

SP-14957 (R8/07)
803256

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# Consent Form I

## I. Authorization for Treatment

I, patient/patient's legal representative, agree to permit performance of such diagnostic, evaluation and therapeutic procedures that the physician(s) deems necessary for my treatment and care.

## II. Authorization to Release Information

I authorize the physician(s) and any of their agents to release information as may be necessary for the completion of claims for reimbursement to the appropriate healthcare insurer, agency or any third party which may be liable for all or part of the charges generated for services rendered.

I further understand that such information will be available to other University Hospitals Health System entities as may be necessary for the completion of claims for reimbursement to the appropriate health care insurer, agency or any third party which may be liable for charges.

## III. Assignment of Benefits

In consideration of services received, I assign the benefits payable for services rendered to the physician(s) or designated agents. I direct those insurers to pay such benefits directly to the physician(s) or designated agents. I agree to pay any and all fees that exceed or that are not covered by my insurance coverage and waive any and all notices and demands in the event of non-payment.

This assignment and authorization is valid from the date of signature, unless revoked by written notice to the physician(s) or their agents. This notice must be received prior to release of information.

_____ (patient's initials)

**Out of Network: I am aware that I am choosing to utilize a health care provider that is *not in network* with my insurance plan. Therefore, I accept responsibility for the out of network penalty determined by my insurance company.**

_____ **(patient's initials)**

## IV. Medicare/TRICARE/Champus Payment/NOPP

I certify that the information I gave if applying for payment under Title XVII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus/Humana Military Claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician(s) or their designated agents.

I acknowledge receipt of a copy of the Notice of Privacy Practices. ___ Yes ___ No
**If not**, reason for acknowledgment not received: _____

_____ _____ _____
Signature patient/legal representative/Relationship Social Security Number Date

_____
Print name of patient / legal guardian