Ramapo Valley Surgical Associates* and *The Center for Breast Health at Good Samaritan Hospital

PATIENT REGISTRATION

FIRST NAME: **MI:**	**LAST NAME:**	
STREET ADDRESS	**ZIP CODE:**	**CITY:**
HOME PHONE:	**WORK PHONE:**	**CELL PHONE:**
PHARMACY NAME & ADDRESS:	**COPAY AMOUNT:**	**EMAIL ADDRESS:**
HOW MANY INSURANCE PLANS?:	**SEX: ( ) Male ( ) Female**	**DATE OF BIRTH:**
RACE (check one): **( ) White ( ) Black/African America** **( ) Native Hawaiian/Other Pacific Islander**	**( ) American Indian/Alaska Native** **( ) Other**	**( ) Asian** **( )Patient Declined/Unknown**
SOCIAL SECURITY #:	**REFERRING DOCTOR:**	**PRIMARY DOCTOR:**
ETHNICITY: **( ) Spanish/Hispanic Origin** **( ) Not of Hispanic Origin** **( ) Patient Declined/Unknown**	**PRIMARY LANGUAGE:** **SECONDARY LANGUAGE:**	**COUNTRY:** **COUNTRY:**

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:			
INS. COMPANY ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
NAME OF INSURANCE POLICY HOLDER:	**DATE OF BIRTH:** **SEX:**	**SOCIAL SECURITY #:**	
INSURED'S POLICY #:	**INSURED'S EMPLOYER:**	**EMPLOYER CITY/STATE/ZIP:**	
INSURANCE GROUP#	**PATIENT'S INSURANCE POLICY #:**	**EFFECTIVE DATE OF INSURANCE:**	
RELATIONSHIP TO INSURED:	**IF AUTO OR WORK RELATED,DATE OF INJURY:**		

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME:			
INS. COMPANY ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
NAME OF INSURANCE POLICY HOLDER:	**DATE OF BIRTH:** **SEX:**	**SOCIAL SECURITY #:**	
INSURED'S POLICY #:	**INSURED'S EMPLOYER:**	**EMPLOYER CITY/STATE/ZIP:**	
INSURANCE GROUP #:	**PATIENT'S INSURANCE POLICY #:**	**EFFECTIVE DATE OF INSURANCE:**	
RELATIONSHIP TO INSURED:	**IF AUTO OR WORK RELATED,DATE OF INJURY:**		

Assignment of Benefits: I authorize payment of medical benefits directly to Bon Secours Medical Group for services rendered.

_____

Signature patient/guardian **date**

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid services or its intermediaries or carriers or to the billing agent of this practice, any information used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

_____

Signature patient/guardian **date**

NAME (PRINT): _____

PRIVACY INFORMATION

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

OK TO LEAVE INFORMATION?

	Appointment Information:	Medical Information:
On home phone (Include Auto Call)?	**___Yes**	**___Yes**
On Cell Phone (Include Auto Call)?	**___Yes**	**___Yes**
On Office Voice Mail?	**___Yes**	**___Yes**
W/ another person?	**___Yes**	**___Yes**
Send via mail?	**___Yes**	**___Yes**
Send via e-mail?	**___Yes**	**___Yes**

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

Name: **Relationship:** **Phone:** **Cell Phone:**

Additional HIPAA Contact Instructions:

Do we have your permission to obtain your medication history from the pharmacy? Yes No

Doctors or Facilities that participate in your healthcare (Name, Address, Phone and Fax #):

I acknowledge that I have been provided a copy of Bon Secours Notice of Privacy Practices and have been given the opportunity to have my questions answered.

_____ _____

Signature/date of patient/guardian **signature/date of witness**