Barnabas Health Medical Group

Today's Date: _____
Who are you seeing today?_____
If seeing a Specialist who is your PCP?_____

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____First Name: _____ MI: _____

Date of Birth: _____ Social Security #: _____
Gender: M □ F □ **Identifies as:**_____ **Orientation:**_____
Marital Status: Single □ Married □ Widowed □ Separated □ Divorced □

Demographic Patient Information

In order to comply with federal regulations, we are required to ask you for the following information:

Preferred Language: English □ Korean □ Spanish □ Chinese □ French □ German□ Hindi □ Italian □ Japanese □ Polish □ Portuguese □ Russian □ Tagalog □ NA □

Ethnicity: Hispanic or Latino □ Not Hispanic or Latino □ Patient Declined □
Race: American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White □ Patient Declined □

Contact Information

I understand that the staff and/or physicians of Barnabas Health Medical Group ("BHMG-UM") may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Preferred Comm.: Phone □ Email □ Letter □ **PHI on Voicemail:** Yes □ No □ **Prev Reminder:** □ Email □ Letter □ Decline □

Home Phone: ( ) _____ **Cell Phone**: ( ) _____ **Work Phone:** ( ) _____
Main Contact: Home □ Cell □ Work □

Email: _____ **Email Health Info: ?** Yes □ No □ **Direct:**_____

Address: _____
Street City State/Zip

Disclosure to Designated Family/Friends/Caregivers

I allow BHMG-UM to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing any time.

_____ _____
Name Relationship Phone Number

_____ _____
Name Relationship Phone Number

Emergency Contact: Disclose medical information? Yes □ No □

_____
Name Relationship Phone Number

How did you hear about us? : Patient_____ Website_____
Other:_____

Insurance Information (Present Insurance Card(s) to Receptions)

Are you the Policyholder: Yes □ No □ , **Please complete if the answer is No**

Last Name: _____ **First Name:** _____ **MI**: _____

Date of Birth: _____ **Your Relationship to Policy Holder:** Spouse □ Child □ Other □

Secondary Insurance: Yes □ No □ **Your Relationship to Policy Holder:** Spouse □ Child □ Other □

EMR/Pharmacy

Pharmacy Name: _____ **City/State**:_____ **Phone Number**: ( ) _____

Do you have a prescription Plan? Yes □ No □ **Preference:** Brand □ Generic □
Do you have a health care proxy/living will? Yes □ No □

□ **No Known Allergies**
Allergies: Latex □ Food _____ Medications:_____

Authorization to Access Electronic Prescription Records

I authorize Barnabas Health Medical Group - UM ("BHMG-UM") and its affiliated providers to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my BHMG-UM medical record.

Health Information Exchange (HIE)

BHMG-UM-UM also participates in electronic health information exchanges (HIEs) with hospitals and various other health care providers. I authorize BHMG-UM and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs, and instructions on how to do that can be found in the BHMG-UM Notice of Privacy Practices, the HIE brochure which is available from participating BHMG-UM offices, or may be requested from BHMG-UM's Privacy Officer.

Release and Assignment of Benefits

I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the providers in BHMG-UM for services rendered on my behalf. I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, co-payments and benefits services that are out of network, denied and/or not covered by my health insurance plan. I authorize BHMG-UM or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

Consent to Treat

I, the undersigned, voluntarily consent to and authorize BHMG-UM through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my BHMG-UM physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment

Acknowledgments and Agreement

□ I acknowledge that I have been advised of my right to an Advance Directive.
□ I acknowledge receipt of the BHMG-UM Financial Policy, and agree to all the terms and conditions contained therein.
□ I acknowledge receipt of the Notice of Privacy Practices.
□ I agree to allow access to my electronic prescription records as described above.
□ I agree to the release and assignment of benefits as described above.
□ I agree to treatment as described above.
□ I have read this form, my questions have been answered, and I understand and agree to its content.

_____ _____
Patient/Representative's Signature Date

_____ _____
If signed by Authorized Representative, print name of Signatory Relationship to Patient/Authority to Sign for Patient

Barnabas Health Medical Group

Today's Date: _____

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth_____

MEDICATION/ALLERGY LIST

□ **No Known Allergies**
Allergies: Latex □ Food _____ Medications:_____

Allergies	Description of Reaction(s)

LIST ALL MEDICATIONS YOU TAKE, (INCLUDING OVER THE COUNTER, HERBAL, NATURAL REMEDIES)				
Medication	**Strength**	**How often is Rx Taken**	**Reason for Medication**	**Date Started**

New Jersey Depart of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609*826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNICATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

*RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD

REGISTRANT INFORMATION	PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)
Registrant name	Name
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.
I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C> 8:57-3
I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program:

□ Yes, I would like to participate in this program.
□ No, I do not want to participate in this program.

_____ _____
Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age) Date