BOCA GRANDE HEALTH CLINIC

PATIENT REGISTRATION

Patient Information:

Last Name | First Name | Middle Name

Date of Birth | Gender | Social Security Number | Marital Status

Race (check one): ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other Race ☐ I Decline to Answer

Ethnic Group (check one): ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ I Decline to Answer

Preferred Language: _____ **Preferred Pharmacy:** _____

Primary Contact Information: (Note: U.S. address is required in order for us to submit prescriptions.)

Home Phone # | Cell Phone # | Personal Fax # | Work Phone #

Home P.O. Box | Home Street Address

City | State | Zip Code

Email _____

Other Contact Information: (Northern Address if applicable)

Home Phone # | Cell Phone # | Personal Fax # | Work Phone #

Home P.O. Box | Home Street Address

City | State | Zip Code

Preferred Means of Contact:

Choose one: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Mail ☐ Email ☐ Patient Portal

For Email:
No medical information or other protected health information will be sent via regular (unsecure) email. Patients wishing to receive medical or other protected health information electronically should select the Patient Portal. Please be sure you have provided your email address above if it is your preferred means of contact.

Patient Reminders:

Choose one: ☐ Email ☐ Patient Portal ☐ Phone

Other Contact Instructions:

- May we leave a message on your home phones listed above? ☐ Yes ☐ No
  (If "yes" may we include medical information? ☐ Yes ☐ No)
- May we leave a message on your cell phones listed above? ☐ Yes ☐ No
  (If "yes" may we include medical information? ☐ Yes ☐ No)
- May we leave a message on your work phones listed above? ☐ Yes ☐ No
  (If "yes" may we include medical information? ☐ Yes ☐ No)
- May we mail test results or reports to your addresses listed above? ☐ Yes ☐ No

Patient Portal:

All patients of Boca Grande Health Clinic are automatically enrolled in the Online Patient Portal, unless specifically declined in writing. If you would prefer not to participate, please check the following statement.

☐ I hereby decline to participate in the Boca Grande Health Clinic Patient Portal.

Primary Care Physician Contact Information:

When you are in Boca Grande, do you consider one of the physicians at the Boca Grande Health Clinic your primary care provider? ☐ Yes ☐ No Name of your primary care physician: _____

Information Exchange

I hereby consent to the exchange of my health and immunization information data necessary for my care.

Insurance Information:

- ☐ Medicare
- ☐ Evolutions
- ☐ Other Insurance

Please provide driver's license or other photo identification and insurance cards to Patient Representative

Guarantor Information:

Last Name	First Name	Middle Name	Relationship to Patient
Date of Birth	Gender	Social Security Number	
Home Phone #	Cell Phone #	Personal Fax #	Work Phone #
P.O. Box	Street Address		
City		State	Zip Code

Employment:

Employer			Phone
Employer's Address	City	State	Zip Code

Note: If any office visit is due to a job-related injury or automobile accident, please inform the patient representative

Advance Directives:

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

If you have any of the above-mentioned Advance Directives, please provide the Boca Grande Health Clinic with a copy for your chart. If you would like more information regarding Advance Directives, please ask your patient representative for additional information.

Emergency Contact Information:

Name	Address	City	State/Zip Code
Home Phone #	Work Phone #	Cellular Phone #	Relationship

Access to Your Information by Others:

List those persons who may have access to your information. Select which information you wish us to share.

Name	Relationship	Appointment	Medical	Billing
_____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Card on File Information:

If you prefer to pay by credit card and wish to leave a card securely on file with the clinic, please provide your credit card information below to be used at the end of your visit(s).

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Security Code: _____

Authorization:

INSTRUCTIONS: I hereby authorize Boca Grande Health Clinic, Inc. to contact me in the manner indicated above and allow access to my information to the individuals indicated in the manner as directed herein.

I acknowledge that I was provided a copy of the notice of privacy practices and that I have read (or had the opportunity to read if I so choose) and understood the information provided.

I acknowledge that I was provided with a copy of Patient Rights and Responsibilities and that I have read (or had the opportunity to read if I so choose) and understood the information provided.

I acknowledge that I have received a copy of the Patient Portal Terms of Use and have/will read and agree to abide by those terms unless I have declined to participate in the Patient Portal. I understand that this service is provided free of charge as a courtesy to Clinic patients. Patients who elect not to use the Portal will still have access to all of the Clinic services normally available to patients.

RELEASE OF INFORMATION: I hereby authorize Boca Grande Health Clinic, Inc., and its physicians and/or staff involved in my care, to release any information acquired in the course of my examination or treatment to other healthcare providers to whom I have been referred to by a Boca Grande Health Clinic physician and/or any third party payer (e.g. Medicare, Blue Cross and Blue Shield of Florida, etc.) when requested for its use in connection with determining a claim for payment for such examination or treatment.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Boca Grande Health Clinic, Inc., and its physicians involved in my examination or treatment, for any services covered by any third-party payer for my examination and treatment for which Boca Grande Health Clinic, Inc., may elect to accept assignment.

ACKNOWLEDGEMENT: I understand that Boca Grande Health Clinic, Inc. does not routinely participate as a network provider with health plans or accept assignment from third party payers and I acknowledge that I am financially responsible for payment, at the time of service, whether or not covered by any third-party payer.

_____

Signature of Patient or Guardian Date