pacific medical centers

REGISTRATION FORM

PATIENT LABEL HERE

PATIENT INFORMATION

Last Name (Legal)	First Name, Middle Name (Legal)		Preferred Name	
Previous Name(s)	Social Security Number	Sex ☐ Female ☐ Male ☐ Other	Date of Birth	Marital Status
Gender Identity ☐ Female ☐ Transgender Female / Male to Female ☐ Other / Non-Binary ☐ Male ☐ Transgender Male / Female to Male ☐ Prefer Not to Disclose	Patient Preferred Pronouns ☐ She / Her ☐ He / Him ☐ They / Them		Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline	
Address	City		State	Zip Code
Home Phone	Work Phone	Cell Phone		Email
Preferred Language / Need Interpreter ☐ Yes ☐ No	Communication Assistance ☐ Hearing ☐ Speech ☐ Vision ☐ Other	Race ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Native Hawaiian or other Pac Islander ☐ Other ☐ Decline		
Employer Name	Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Unemployed ☐ Retired		Retirement Date (if applicable)	Occupation
Emergency Contact Name	Emergency Contact Number		Relationship	
Primary Care Provider	Primary Care Provider Phone #	Referred? ☐ Yes ☐ No	Referred by Name/Phone #	

GUARANTOR/LEGAL GUARDIAN (If patient is 18 or older, guarantor is self)

Does adult patient have "legal guardian" or durable power of attorney for health care? (If Yes, please complete the fields below and provide guardianship court order or durable power of attorney for health care document)			
Last Name	First Name, Middle Name	Relation to Patient	
Home Phone	Social Security Number	Sex ☐ Female ☐ Male ☐ Other	Date of Birth
Address	City	State	Zip Code
Employer Name	Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Unemployed ☐ Retired	Retirement Date (if applicable)	Occupation

PRIMARY INSURANCE

Insurance Company Name	Group Number	Subscriber ID Number		Copay Amount
Subscriber's Name (Policy Holder)	Social Security Number	Date of Birth	Sex ☐ Female ☐ Male ☐ Other	Relationship to Patient
Subscriber's Employer Name	Subscriber Employment Status	Subscriber Home Phone		Subscriber Work Phone

SECONDARY INSURANCE

Insurance Company Name	Group Number	Subscriber ID Number		Copay Amount
Subscriber's Name (Policy Holder)	Social Security Number	Date of Birth	Sex ☐ Female ☐ Male ☐ Other	Relationship to Patient
Subscriber's Employer Name	Subscriber Employment Status	Subscriber Home Phone		Subscriber Work Phone

CONSENT TO CARE:
I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that Pacific Medical Centers participates in the training of physicians and other healthcare providers and I will be told when trainees take part in my care.

Initial

NOTIFICATION OF RELEASE FOR PAYMENT:
I understand that Pacific Medical Centers will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions.

Initial

FINANCIAL AGREEMENT:
I understand co-payments are due at the time of service. I assign payment from my insurance directly to Pacific Medical Centers. I understand I am financially responsible to Pacific Medical Centers for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider. I may also receive separate bills from the laboratory, radiology and other specialized services.

Initial

RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES:
I have received a copy of the Pacific Medical Centers **Notice of Health Information Practices** which provides information about how my health information may be used and disclosed.

Initial

I have read the above and understand its contents:

Print Name	Date	Print Name	Date
Patient Signature		Guardian/Legal Representative Signature	

Data entered into Epic
☐ Insurance card scanned
☐ Drivers license/picture ID scanned

**We value your privacy and may share your contact information with trusted partners to assist us in enhancing your experience with PacMed. Your medical information is never shared.

PATIENT LABEL HERE

Medicare

Medicare Number:_____ Part A ☐ Part B ☐

MEDICARE QUESTIONNAIRE – Required for all Medicare Patients
MSP Information

1. Are you over 65 years of age and is this why you have Medicare Part B benefits? ..... Yes / No
2. Are you employed right now? ..... Yes / No
3. Is your spouse employed right now? ..... Yes / No
4. Are you covered by a health plan from your own or family member's current employment? ..... Yes / No
   - ↳ Does the employer have 20 or more employees? ..... Yes / No
5. Are you or your spouse retired? ..... Yes / No
   - ↳ Your retirement date: _____/____/_____
   - ↳ Spouse's retirement date:_____/____/_____
   - ↳ Spouse's name:_____
6. Do you have Medicare because of end stage renal disease (ESRD)? ..... Yes / No
   - ↳ Is ESRD the reason you first became eligible for Medicare? ..... Yes / No
     - ↳ Are you within the first 30 months of treatment for ESRD? ..... Yes / No
7. Is the reason you have Medicare due to a disability, other than ESRD? ..... Yes / No
   - ↳ Are you covered by a group health plan of an employer with over 100 employees? ..... Yes / No
8. Has the Department of Veterans Affairs (VA) authorized and agreed to pay for the services at this facility today? ..... Yes / No

   Note: VA benefits are separate from TRICARE medical coverage. A "yes" answer means the VA sent you here today.
9. Were you a coal miner and are you entitled to benefits under the Federal Black Lung Program? ..... Yes / No
10. Is this illness or injury due to a work related accident, and will your bill today be sent to a Workers' Compensation Carrier primary to or instead of Medicare? ..... Yes / No
11. Is this illness or injury the result of a non-work related accident (i.e. motor vehicle accident)? ..... Yes / No
    - ↳ Do you have non-fault or liability insurance (i.e. auto insurance) that we should bill instead of Medicare for your services today? ..... Yes / No
12. Are services to be paid by a government research program? If yes, please provide billing instructions to the front desk ..... Yes / No

May we leave detailed health Information on a voicemail for you? Yes_____ No_____ (Place "X" on the line).

If yes, please provide us with a phone number in which we may leave a message: Cell / Home / Work _____

On occasion, patients may wish to have a family member or close personal friend assist them with matters related to their care. Please provide us with the full name and relationship of any individual (other than yourself) who you permit PMC to discuss your limited and/or detailed billing and health information with:

Name of individual: _____ Relationship:_____

-OR- Do NOT allow disclosure to any other Individual: _____(Place 'X" on the line).

Pacific Medical Centers complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-4PACMED （TTY：711）。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-4PACMED (TTY: 711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-4PACMED (TTY: 711).

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