THE HUNTINGTON HEART CENTER

172 EAST MAIN STREET, HUNTINGTON, NY 11743
TEL: (631) 385-0022 • FAX: (631) 385-0896

PATIENT REGISTRATION

PLEASE USE ONLY BLACK OR DARK BLUE INK

Name: _____

Date of Birth: _____/_____/_____ SS#: xxx-xx-_____ **Sex**: _____

Address: _____ **City**: _____ **Zip**: _____

Home: ( ) _____-_____ **Cell**: ( ) _____-_____ **Work**: ( ) _____-_____

E-mail address: _____

Primary Care Physician: _____ **PCP Phone#:** ( ) _____-_____
** *PLEASE PROVIDE* FIRST & LAST NAME *OF PRIMARY CARE DOCTOR* **

Emergency Contact: _____ **Phone #:** ( ) _____-_____

INSURANCE INFORMATION

Primary Insurance: _____**ID#**:_____

Secondary Insurance: _____ **ID#**: _____

Name of Insured: _____ **DOB**: _____/_____/_____

I understand that I will be held liable for payment of all services rendered to me by my physician at the Huntington Heart Center if I have provided incorrect insurance information which results in non-payment on any date of service. I understand there are cancellation & a no show charge of $25 if I do not inform the office within 24 hours of my appointment. The fee for cancellation & no show for Thallium Stress Test is $200 and the fee for PET scans is $500, unless there is an emergency.

Patient Signature: _____ **Date:** _____

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Last Name: _____ **First Name**: _____ **DOB**: ____/_____/_____

I, _____(do_____/do not_____) give permission for any staff member of the **HUNTINGTON HEART CENTER** & it's Physicians, to speak with a family member or individual regarding appointments, prescriptions, financial matter, tests results or pick up records & films on your behalf.

Please list the individuals that we may speak with:

Name: _____ Relationship: _____ Phone #: ( ) _____-_____

Name: _____ Relationship: _____ Phone #: ( ) _____-_____

Name: _____ Relationship: _____ Phone #: ( ) _____-_____

****May we leave a voicemail recording regarding your appointment or a message to call us back?****

YES _____ NO_____

Authorization for Release of Information via E-mail

By providing your e-mail address, you agree to receive information about your protected health information as well as upcoming appointments that are scheduled.

YES_____ NO_____

Authorization to Access Prescription History

I hereby authorize my physician(s), to download my prescription history through computer networks operated by Surescripts Clearinghouse, a provider of electronic prescribing services, in connection with providing my health care services.

YES_____ NO_____

Authorization for Release of Information/Assignment of Benefits

I hereby authorize and direct my physician(s), having treated me, to release to other treating physicians, insurance carries, government agencies, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to my physician(s), sufficient monies and/or benefits I may be entitled from government agencies, insurance carries and others who are financially liable for medical costs of the care and treatment rendered to me or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

_____ _____

Signature **Date**

I have read & understood the HIPAA Notice of Privacy Practices of the Huntington Heart Center. I understand how the practice will handle my personal health information.

_____ _____

Signature **Date**

Rajeswara Rao Patcha, M.D., P.C. d/b/a

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print Patient's name) _____, acknowledge and agree that I have reviewed the practice's Notice of Privacy Practices ("Notice") and a copy of such Notice is available on the practice's website or in paper copy upon my request.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to Patient

FOR PRACTICE USE ONLY:

The Huntington Heart Center has made the following good faith efforts to obtain the above-referenced Patient's written acknowledgement of receipt of the Notice of Privacy Practices:
[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]

PLEASE HAND THIS FORM TO THE MEDICAL ASSISTANT WHEN YOU ARE CALLED INTO THE ROOM

Name:_____ DOB:_____ Date:_____

Approximate Height: _____ Approximate Weight:_____

Of the languages below, please circle only *ONE* that you prefer:

English Spanish Chinese Italian French German Japanese Russian

Of the choices below, which best defines your ethnicity:

[ ] Hispanic/Latino [ ] Non-Hispanic/Latino [ ] Neither choice applies

Of the choices below, *CIRCLE* which best describes your race:

American Indian/Alaskan Native Asian Black or African American

Native Hawaiian or other Pacific Islander White Other

Do you have any known *DRUG ALLERGIES*?

[ ] No known drug allergies [ ] Ace Inhibitors [ ] Aspirin [ ] Codeine/Other Opiates [ ] Erythromycins

[ ]IVP Dye,Iodine Containing [ ] NSAIDS/Ibuprophen/Aleve [ ] Penicillins [ ] Sulfa Drugs [ ] Tetracyclines

Cigarette smoking history, please circle *ANY* that apply:

Current every day smoker Current some day smoker Former smoker Never smoker

Smoker, current status unknown

Please list prescription medications AND dosage:

- _____ -_____
- _____ - _____

Please list the Name, Address, City, Zip code & Phone Number of the Pharmacy(s) you use:

1. _____
2. _____

PLEASE HAND THIS FORM TO THE MEDICAL ASSISTANT WHEN YOU ARE CALLED INTO THE ROOM