PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY AS YOU COMPLETELY ANSWER EACH QUESTION BELOW
PLEASE REVIEW THE *NOTICE OF PRIVACY PRACTICES* AND *FINANCIAL POLICY*
THAT HAVE BEEN PROVIDED TO YOU ALONG WITH THIS REGISTRATION FORM

CARE STATION MEDICAL GROUP
328 W St. Georges Ave, Linden, NJ 07036
www.CareStationMedical.com
(908) 925-2273

SECTION 1: PLEASE INDICATE IF ANY OF THE SITUATIONS BELOW APPLY & COMPLETE SECTION 2 ACCORDINGLY

☐ **WORK RELATED INJURY?**

PLEASE ALSO COMPLETE **BOX G** ON THE REVERSE SIDE OF THIS SHEET

☐ **EMPLOYER-RELATED SERVICE?**

PLEASE ALSO COMPLETE **BOX H** ON THE REVERSE SIDE OF THIS SHEET

☐ **RESULT OF A MOTOR VEHICLE ACCIDENT?**

Date of accident: ___/___/___
Auto Insurer: _____
Policy#: _____

SECTION 2: PLEASE COMPLETE ALL SECTIONS BELOW & SIGN ON THE REVERSE SIDE OF THIS SHEET

A: PATIENT INFORMATION

Name: _____ (First) ___ (MI) _____ (Last) Gender: ☐ M ☐ F DOB: ___/___/___ (M D Y)

Marital Status: ☐ Not Applicable – Child ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

SOC SEC #: -- --
(Not required if Patient is under the age of 18, in which case complete Box F below)

Based on Government regulations, we are required to gather the following information on the Patient:

Race: ☐ African American ☐ American Indian or Alaska Native ☐ Asian ☐ Caucasian ☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino **Preferred Language:** _____

Street: _____
Apt #: _____ City: _____
State: _____ Zip: _____ Country: _____ (If not U.S.)

Home Tel: ( ) ---
Mobile Tel: ( ) ---
E-mail: _____
☐ Indicate preferred contact method

B: EMERGENCY CONTACT INFORMATION

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

ADDRESS: ☐ **Same as that of Patient**
Street: _____
Apt #: _____ City: _____
State: _____ Zip: _____ Country: _____

C: HOW DID YOU HEAR ABOUT US?

☐ Google/Search ☐ Facebook ☐ Yelp ☐ Ad ☐ Sign
☐ Friend/Family ☐ Physician ☐ Job/Employer ☐ School
☐ Insurance Co. ☐ Pharmacy ☐ Other: _____

D: INSURANCE INFORMATION

☐ **SELF-PAY**

Primary Insurance _____ Secondary Insurance _____

IF SOMEONE OTHER THAN THE PATIENT HOLDS THE INSURANCE, PLEASE COMPLETE THE FOLLOWING FOR THE PRIMARY INSURANCE SUBSCRIBER

Subscriber: _____ Relationship To Patient: _____
DOB: ___/___/___ Soc Sec # -- --

E: PRIMARY CARE PHYSICIAN (PCP)

☐ **DO NOT HAVE A PCP**

PCP Name: _____
Practice Name: _____
City: _____
State: _____ Zip: _____ Country: _____ (If not U.S.)
Phone #: ( ) --

F: Patient UNDER the age of 18?

Complete the following for Parent or Guardian:

Name: _____ DOB: ___/___/___
Soc Sec # --- ---

PLEASE TURN OVER >>>

G: WORKER'S COMP INFORMATION

Date of Injury: ____/____/____

Employer: _____

Street: _____

City: _____ State: _____ Zip: _____

Manager/
HR Name: _____

Tel : (_____) _____ Fax : (_____) _____

E-mail: _____

H: MEDICAL SURVEILLANCE INFORMATION

Employer: _____

Street: _____

City: _____ State: _____ Zip: _____

Manager/
HR Name: _____

Tel : (_____) _____ Fax : (_____) _____

E-mail: _____

CONSENT FOR TREATMENT AND RELEASE OF MEDICAL RECORDS

I give my permission to Care Station and its staff to perform the following procedures AS DEEMED NECESSARY, including, but not limited to, the taking of health history, physical examination or diagnostic procedures such as x-ray, electrocardiogram, audiogram, pulmonary function and venipuncture (drawing of blood) for laboratory tests and treatment for my injury / illness. If I should become ill while undergoing treatment by Care Station and its staff, I give Care Station and its staff my permission to administer treatment which in their opinion would be considered as necessary for my well being.

I understand that information regarding the results of my physical exam, diagnostic procedures and/or nature of my illness will be released to the insurance carrier providing coverage to me. I consent to having my medical information transferred to any physical and/or health care institution that I am referred to by Care Station. I understand medical information will be communicated to a designated representative of my employer or prospective employer (only if this is a workers' compensation case or an employer-paid service).

NOTICE OF PRIVACY PRACTICES & PERMISSION OF PATIENT CONTACT

I permit Care Station to discuss my healthcare information with the person(s) listed below:

Name: _____ Tel: _____

Name: _____ Tel: _____

I authorize Care Station to obtain my prescription history from the electronic database of pharmacies through the electronic medical records system used by Care Station. I understand that this history, once obtained, will become part of my medical record. *My signature below indicates my consent for treatment and release of medical records, and that I have received and reviewed the **Care Station Notice of Privacy Practices** and **Financial Policy**.*

In accordance with the Financial Policy that I have reviewed, I agree to take full financial responsibility for payment of all fees and charges due to Care Station associated with the services provided to me by Care Station. I understand that in addition to my signature below, any signature provided electronically and stored in Care Station's system will effectively serve as my acknowledgement and acceptance of all of the above.

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____

For Internal Use >>> ***SCANNED:*** ☐ ID ☐ INS ☐ REGN >>> ***PMT:*** ☐ VISIT >>> ***APRIMA:*** ☐ ALL FIELDS ENTERED >>> ***REG INITIALS:*** _____