COMPASS MEDICAL PC
Exceptional Medicine. Compassionate Care.

Account #: _____
Date: ____/____/____
PCP: _____

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

First Name_____MI_____Last Name_____ Suffix_____

Previous Name_____Preferred Name_____Birth Date_____Sex ☐Female ☐ Male

Address_____City_____ State_____Zip_____Country_____

**While Compass Medical recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.*

If a Child, Parent/Guardian's First Name_____MI_____Last Name _____

Please select a primary phone number by checking the appropriate box below

☐Home Phone (____)_____ ☐Cell Phone (____)_____ ☐Work Phone (____)_____

Marital Status ☐Married ☐Single ☐Divorced ☐Legally Separated ☐Partner ☐Widow

Email Address _____

By giving Compass Medical, P.C. my email address, I understand I am giving them permission to send me health related Information through my email with the confidence of knowing that I may safely unsubscribe at any time.

Preferred Method of Contact ☐ Letter ☐ Email

Employment Status ☐Employed ☐Retired ☐On Active Military Duty ☐Unemployed ☐Other

Student Status ☐Student ☐Not a Student

EMERGENCY CONTACT

First Name_____MI_____Last Name _____

Address_____City_____State_____Zip_____

Home Phone (____)_____Cell Phone (____)_____Work Phone (____)_____

Relationship to Patient ☐Parent ☐ Spouse ☐ Partner ☐Child ☐Sibling ☐ Grandparent ☐Other_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Company_____Phone Number (____)_____

Subscriber Name _____Relationship to Patient_____Birth Date _____

Policy #_____Group #_____Effective Date _____

SECONDARY INSURANCE:

Insurance Company_____Phone Number (____)_____

Subscriber Name _____Relationship to Patient_____Birth Date _____

Policy #_____Group #_____Effective Date _____

PHARMACY

Preferred Pharmacy Name_____Phone (____)_____

Address_____City_____State _____

HOW DID YOU HEAR ABOUT US? (Please check one.)

☐ Insurance Company ☐ Non-Compass Provider Referral ☐ Online Ad

☐ Compass Medical Website ☐ General Internet Search ☐ Other: _____

PATIENT DEMOGRAPHICS

Studies have shown there are health differences among different racial and ethnic groups. Your answers will help us make informed clinical decisions for improved delivery of your health care. Providing this information is voluntary and will be kept confidential and will only be used to meet the needs of the patients we serve.

1. Which of the following best describes your Race?

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Declined to Specify
☐ Native Hawaiian or other Pacific Islander ☐ White/Caucasian ☐ Other: _____

2. Preferred Language?

☐ English ☐ Portuguese ☐ Creole: _____ ☐ Sign Language: _____ ☐ Declined to Specify
☐ Spanish/Castilian ☐ Chinese ☐ Urdu ☐ Other: _____

3. Which of the following best describes your Ethnicity?

☐ Not Hispanic or Latino/a ☐ Hispanic or Latino/a ☐ Other: _____ ☐ Declined to Specify

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

(For Medicare Patient Use Only)

Name of Beneficiary (Patient)_____ **HICN #** (Medicare #) _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in Compass Medical, P.C. including physician services. I authorize any holder of medical or other information about me be released to the Centers for Medicare and Medicaid and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient:_____ **Date:** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Compass Medical, P.C. Notice of Privacy Practices (included in the back of this packet) and I understand that I may request a copy of this notice at any time.

By signing my name below, I agree to the above information.

Signature of Patient or Responsible Party:_____ **Date**: _____

PRESCRIPTION HISTORY CONSENT

I authorize Compass Medical to obtain a history of my prescriptions during the course of medical care by Compass Medical Physicians and Providers.

By signing my name below, I agree to the above information.

Signature of Patient or Responsible Party:_____ **Date**: _____