Garner Internal Medicine P.A.

# PATIENT REGISTRATION FORM

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|---|---|
| Select a Provider: (Circle One) | Dr. Steven Turner / James McCann PA-C<br>Dr. Jeffrey Breiner / Amy McAlister FNP / Angela Keene FNP<br>Dr. Karen Mayer / Amy McAlister FNP / Angela Keene FNP |

**Please be advised that our Physicians do NOT share patients within the practice. Once a Physician is selected you will see the selected Physician or his/her Nurse Practitioner or Physician Assistant.**

Social Security #:_____-____-_____ Date of Birth: _____/_____/_____ Sex: Male/ Female

Last Name: _____ Middle Initial: _____First Name: _____

Street Address: _____

City/State/Zip: _____

Home Phone #:_____Cell #:_____

Email Address:_____

(You will receive an invitation to register for our secure online portal via email)

Patient's Employer: _____Work #:_____

Employer's Address: _____ Occupation: _____

City: _____State/Zip: _____

Marital Status (circle one): Single, Married, Widowed, Separated, Divorced, Other

Spouse's Name: _____

**If you have Medicare, are you or your spouse currently working? (circle one) ◯Yes ◯No**

**Primary Insurance Information:**

Name of Insurance: _____

Name of Subscriber: _____SS#:_____-_____-_____

DOB of Subscriber: _____/_____/_____Subscriber's Employer:_____

Subscriber's Employer's Address: _____

**Secondary Insurance Information:**

Name of Insurance: _____

Name of Subscriber: _____SS#:_____-_____-_____

DOB of Subscriber: _____/_____/_____Subscriber's Employer: _____

Subscriber's Employer's Address: _____

**First Emergency Contact:**

Name: _____Phone#:_____Relationship:_____

**Second Emergency Contact:**

Name: _____Phone#:_____Relationship:_____

**Ethnicity (circle one):** Hispanic, Non-Hispanic, Patient Declines

**Race (circle one):** American Indian, Asian, Black or African American,

Native Hawaiian or other Pacific Islander, White, Patient Declines

**Preferred Language (circle one):** English, Spanish, Other_____

**Preferred method of communication for follow up care (circle one)**: Phone, Mail, Patient Portal

**How will you be paying today?** (circle one) Cash, Check, Visa, MasterCard, Discover

It is the policy of Garner Internal Medicine, P.A. to communicate only with the patient using the contact information provided by the patient. HIPAA of 1996 establishes the right for patients to request alternative methods of communication from our office. **If there is anyone, other than yourself, that you would like GIM to release information to, please list them below. Please note that we will not be able to communicate with anyone other than you without your written permission.**

Name: _____Relationship:_____

(**Circle one or both**) Medical Info / Billing Info.

**If this request changes you are responsible for notifying GIM.**

I AUTHORIZE THE PHYSICIAN IN CHARGE TO ADMINISTER MEDICAL CARE AS IS NECESSARY. GARNER INTERNAL MEDICINE WILL FILE YOUR INSURANCE AT THE TIME OF SERVICE. IF YOUR INSURANCE REQUIRES THAT YOU PAY A DEDUCTIBLE OR CO-INSURANCE YOU ARE RESPONSIBLE FOR PAYING THAT AT THE TIME OF SERVICE. IF YOU HAVE NO INSURANCE YOU WILL BE REQUIRED TO PAY IN FULL AT THE TIME OF SERVICE. WE WILL ACCEPT CASH, CREDIT CARD OR PERSONAL CHECKS.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR CHARGES INCURRED AT GARNER INTERNAL MEDICINE REGARDLESS OF THIRD PARTY LIABILITY. I AGREE THAT GARNER INTERNAL MEDICINE MAY RELEASE ANY MEDICAL INFORMATION NECESSARY FOR FILING MY CLAIM.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION IN POSSESSION OF GARNER INTERNAL MEDICINE TO ANY CONSULTING MEDICAL PERSONNEL FOR THE PURPOSE OF RENDERING TREATMENT OR TO CONTINUE MY CARE.

Patient's Signature: _____Date:_____

Signature of Personal Representative: _____Date:_____

(Effective Date: 08/2013 – Revision 08/2013)