NORTHWEST MEDICAL CARE, LLC

REGISTRATION FORM

(Please Print)

Today's date:	PCP: **KRITHIKA MULLENGADA, MD**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid / Partner

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Race?

❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian or other Pacific Islander

❑ White ❑ Other

Ethnicity?

❑ Hispanic or Latino ❑ Not Hispanic or Latino

Language? ❑ English ❑ Indian (Including Hindi and Tamil) ❑ Russian ❑ Spanish ❑ Other	Email Address?

Street address:	Social Security no.:	Home phone no.: ( )	Cell Phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Work phone no.: ( )

Chose Dr. because/Referred to Dr. by (please check one box):			❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	

Other family members seen here:	Pharmacy & Location:

INSURANCE INFORMATION

(Please give your insurance card and Drivers License to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of Northwest Medical Care, LLC Notice of Privacy Practices (NPP). This practice reserves the right to change the terms of its Notice of privacy Practices and to make new provisions effective for all protected health information (PHI) that it maintains. I understand that I can obtain a copy of the current NPP on request.

Patient Signature:	*Date:*	*DOB:*
Relationship to patient (if signed by a personal representative of patient):		

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives patients the right to request a restriction on uses and disclosures of their protected health information (PHI). You are also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to your office instead of your home.

Please list family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Name:	*Phone no:*
Name:	*Phone no:*

Please list family members or other persons, if any, whom we may inform about your general medical condition **ONLY IN CASE OF EMERGENCY**:

Name:	*Phone no:*
Name:	*Phone no:*

I wish to be contacted in the following manner (**Check all that applies**)

- ❑ Cell Phone No. ( )
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number **only**
- ❑ Home Phone No. ( )
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number **only**
- ❑ Work Phone No. ( )
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number **only**

Patient Signature:	*Date:*	*DOB:*
Relationship to patient (if signed by a personal representative of patient):		

Do you currently have any of the following? (**Please provide copies)**

A Health Care proxy?	❑ Yes ❑ No	A Financial Power of Attorney?	❑ Yes ❑ No
A Legal Guardian?	❑ Yes ❑ No	A Health Care Power of Attorney?	❑ Yes ❑ No
A Living Will?	❑ Yes ❑ No	A Physician's Do Not Resuscitate Order?	❑ Yes ❑ No

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Mullengada. I authorize examination and treatment for this and all following physician visits. I understand that I am financially responsible for all charges & deductibles not covered by my insurance. I also authorize Northwest Medical Care, LLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _______________ *Date* _______________