New Patient Registration Form

Family Medicine at Sterling Ridge

Patient Information

Patient Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)	City	State	Zip
Cell Phone #	Other Phone #	E-mail	
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Social Security #	Driver's License #
Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name (If Applicable)		
Employer Name	Employer Address		
Primary Care Physician Name	Phone #	Referring Physician Name	Phone #

How did you hear about the practice and/or the provider you are seeing today?

❑ Family Member _____ ❑ Established Patient _____

❑ Hospital _____ ❑ ER _____ ❑ Insurance Listing

❑ Physician Referral _____ ❑ Web Search ❑ Location/Drive By

Responsible Party

Complete this section only if the patient is a minor

Responsible Party Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Social Security #	Driver's License #

Insurance & Subscriber Information

Primary Insurance Company	Effective Date	**Secondary** Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City	State / Zip	City	State / Zip
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City	State / Zip	City	State / Zip

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Version: 03/15/15

Health Information Sharing & Emergency Contact(s)

Family Medicine at Sterling Ridge

I authorize Family Medicine at Sterling Ridge to share my medical information with the following individual(s)

Name (please print)	Phone

In an emergency I authorize Family Medicine at Sterling Ridge to contact

Name (please print)	Phone

Signature of Patient, Parent, or Legal Guardian **Date**

Consent to Treat & Financial Responsibility

Family Medicine at Sterling Ridge

Consent to Treat

I hereby authorize employees and agents of Family Medicine at Sterling Ridge (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Parent or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to Family Medicine at Sterling Ridge (hereinafter "FMSR") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to FMSR. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of FMSR, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Version: 03/15/15

TEL 281-419-6565 FAX 281-419-0808

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Address: _____
Mailing Address City State Zip Code

Date of Birth: _____ Social Security Number: _____

Authorizes: **Name of Facility/Physician:** _____

Address: _____

City, State, Zip Code: _____

Please release the following medical information to:

Raja Abusharr, MD
10110 Woodlands Pkwy, Ste 100
The Woodlands, TX 77382

☐ Progress Notes ☐ Operative Reports ☐ Lab Reports ☐ X-Ray Report
☐ Pathology Reports ☐ HIV Test Results ☐ Other (please specify)_____
___Mail Records ___ Fax Records

Purpose of Disclosure: Medical Care
I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall ☐**not expire**; or shall expire in ☐**180 days** from the date of my signature, unless specified in writing here: **(Please choose on of the above)**

_____
Patient's Signature

To The Party Releasing This Information:
I, the undersigned, have read the above and authorize the person or facility noted above to disclose such information as herein contained. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient any may no longer be protected. I hereby release and hold harmless the above named facility or Physician from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____
Patient's Signature **Witness**

_____ _____
Date **Date**