

**PATIENT REGISTRATION FORM**

**Chart #** \_\_\_\_\_ **Date** \_\_\_\_\_

Preferred Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Last First MI

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patients Social Security # \_\_\_\_\_ Marital Status: S M W D

Previous Maiden Names \_\_\_\_\_ Ethnicity: Caucasian White   
Native American   
Employer \_\_\_\_\_ Black/African American   
Asian   
Email \_\_\_\_\_ Latin / Hispanic

**CONTACT INFORMATION**

You have the right to request that our practice contact you about your health needs and related issues in a particular manner. Please be advised that this includes lab and test results, diagnosis, appointment and follow up care plans. Please indicate the acceptable means of contacting you.

Please check primary contact: Appointment Reminder method:  Voice  Email  Text  Don't Contact

- Home # \_\_\_\_\_ Can we leave a message on your machine Y N
- Cell # \_\_\_\_\_ Can we leave a message on your voicemail Y N
- Work # \_\_\_\_\_ Can we leave a message on your voicemail Y N

Who should we contact in the event of an emergency? \_\_\_\_\_ Phone # \_\_\_\_\_

What is their relationship to you? \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary** Insurance Co \_\_\_\_\_ Effective Date \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
Policy Holder's Address \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

**Secondary** Insurance Co \_\_\_\_\_ Effective Date \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
Policy Holder's Address \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

If patient is a minor please indicate who is financially responsible \_\_\_\_\_

**(Please turn over and fill out the reverse side)**

**PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION  
FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS**

1. I understand that as part of my health care, Black Hills Obstetrics and Gynecology originates, records, and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health information may be used or disclosed by Black Hills Obstetrics and Gynecology for treatment, payment, and health care operations. For example, my health information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payor can verify that services billed were actually provided; and
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

2. I acknowledge that I have been provided with Black Hills Obstetrics and Gynecology’s Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy prior to signing this consent. I understand that Black Hills Obstetrics and Gynecology reserves the right to change its Notice of Privacy Practices and prior to implementation will mail a copy of any revised notice to the address I have provided.

3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that Black Hills Obstetrics and Gynecology is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

4. I understand that I may revoke this consent in writing, except to the extent that Black Hills Obstetrics and Gynecology has already taken action in reliance thereon. This signed consent shall remain in force until the undersigned patient gives written notification, stating otherwise.

5. By signing this form, I consent to Black Hills Obstetrics and Gynecology’s use and disclosure of my health information for treatment, payment, and health care operations.

6. I understand that this release of medical information may contain information regarding drug or alcohol abuse, mental health issues and/or HIV (AIDS) and STD (Sexually Transmitted Diseases)

I do not have any restrictions to the use or disclosure of my health information.

I request the following restrictions to the use or disclosure of my health information:

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\_\_\_\_\_ Staff Initials      Restrictions Accepted      Restrictions Denied

7. I, the undersigned, hereby assign to the physician(s) associated with Black Hills Obstetrics & Gynecology LLP. all payments for medical services rendered to myself or my dependant.

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Guardian or Legal Representative** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness** \_\_\_\_\_ **Date** \_\_\_\_\_