NorthStar Surgery
Specialists, P.A.
12319 North Mopac Expressway, Suite 350
Austin, TX 78753
Phone: 512-491-6542 | Fax: 512-491-0161

# Patient Registration Form

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|---|---|---|---|---|---|
| Today's date: | | | PCP: | | |
| **PATIENT INFORMATION** | | | | | |
| Patient's last name: First: Middle: | | | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
| Email Address: | | | Birth date: / / | Age: | Sex: ❑ M ❑ F |
| Street address: | | Social Security no.: | | | Home phone no.: ( ) |
| City: | State: | | ZIP Code: | | |
| Occupation: | Employer: | | | | Employer phone no.: ( ) |
| Preferred Language: ❑ English ❑ Spanish ❑ Other: | | | | | |
| Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino | | | | | |
| Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White | | | | | |

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|---|---|---|---|---|
| **INSURANCE INFORMATION** | | | | |
| (Please give your insurance card to the receptionist.) | | | | |
| Is this patient covered by insurance? ❑ Yes ❑ No | | | | |
| **Name of primary insurance:** | | | | |
| Policy holders name: | Policy holders S.S. #: | Birth date: / / | Group #: | Policy #: |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
| Employer: | Employer address: | | Employer phone #: ( ) | |
| **Name of secondary insurance (if applicable):** | Subscriber's name: | | Group #: | Policy #: |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |

I, the undersigned authorize payment of medical benefits to ***Northstar Surgery Specialists, P.A.*** for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided by me. This information will be used for the purpose of evaluating and administering claims of benefits.

**Patient/Guardian signature** **Date**

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# Additional Information

1. **In case of an emergency**, please list a family member or significant other, if any, whom we may inform about your medical condition:

   Name: _____ Phone Number: _____

2. Please print the address and phone number of where you would like correspondence from our office to be sent if other than your home address and phone. This could include health information such as appointments, lab results, X-ray results, or other information:

   Address: _____

   Phone Number: _____

3. Can confidential messages be left on your:

   Home telephone answering machine: ☐ Yes ☐ No
   Cell phone voicemail: ☐ Yes ☐ No
   Work voicemail: ☐ Yes ☐ No

4. Do you have a LIVING WILL? ☐ Yes ☐ No

5. Do you have a Medical POWER OF ATTORNEY? ☐ Yes ☐ No

   If yes, Name _____ Number _____

6. Pharmacy Information:

   Preferred Pharmacy: _____ Pharmacy Phone #: _____

   Pharmacy Address: _____

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices of NorthStar Surgery Specialists, P.A., which explains in plain language how my protected health information (PHI) will be used and disclosed, my individual rights, and the practice's legal duties with respect to my PHI. I understand that I am entitled to receive a copy of this information upon request.

Signature _____ Date _____