Pleasant Point Health Center

Medical, Dental, Pharmacy, Counseling & Support, Health & Wellness

PATIENT REGISTRATION FORM

PATIENT INFO

FIRST, MIDDLE, LAST NAME			
HOME ADDRESS			
EMAIL ADDRESS			
HOME PHONE #	WORK PHONE #	MOBILE PHONE #	
LANGUAGE	DOB	SOCIAL SECURITY #	MARITAL STATUS
PRIMARY CARE PHYSICIAN	EMPLOYER		
PHARMACY NAME	PHARMACY ADDRESS & PHONE #		

RESPONSIBLE

PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS UNDER AGE 18			
FIRST, MIDDLE, LAST NAME			
HOME ADDRESS			
HOME PHONE #	DOB	SOCIAL SECURITY #	
EMPLOYER NAME	EMPLOYER PHONE #		

INSURANCE INFO

PRIMARY INSURANCE			
PRIMARY INSURANCE NAME	PRIMARY INSURANCE ADDRESS		
SUBSCRIBER NAME	DOB	SEX	
SUBSCRIBER ID #	GROUP #	RELATION TO PATIENT	
SECONDARY INSURANCE			
SECONDARY INSURANCE NAME	SECONDARY INSURANCE ADDRESS		
SUBSCRIBER NAME	DOB	SEX	
SUBSCRIBER ID #	GROUP #	RELATION TO PATIENT	

RELEASE

Release of Information/Assignments of Benefits – Please review and check.

☐ **YES,** I hereby certify that the information I have given is correct to the best of my ability. I authorize PPHC (Pleasant Point Health Center) or its agent to receive medical records information for the purposes of billing. I authorize the PPHC or its agent to access information regarding availability of alternate resources coverage on my behalf. The PPHC is authorized to bill my insurance for covered services provided to me as a patient of its clinic. I further authorize payments to be made directly to the PPHC at PO Box 351, Perry, ME 04667.

HIPPA Notice of Privacy Practices – Did you receive a copy of your privacy practices?

☐ **YES**, I acknowledge that I received a copy of the PPHC Privacy Polices that outlines how my personal health information may or may not be used and that I have certain rights that I may exercise at any time. I also further understand these policies and have been given the opportunity to ask questions or discuss what these policies mean and how they impact me.

Consent for Treatment

☐ **YES**, I authorize PPHC/Providers consent for treatment for conditions that I present for and authorize services as a result of a treatment plan that my provider and I agree upon, subject to the Provider's licensure, training, experience, and scope of services of the PPHC.

Patient's Signature: _____ **Date:** _____

If you would like to opt out of this agreement, please speak to your provider.