TRUMANSBURG FAMILY MEDICINE
REGISTRATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

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

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

Street address:	Cell phone no:	Home phone no.:
		( )

P.O. box:	City:	State:	ZIP Code:
	Email address:	Full-time Student? ____Yes____ No	

Occupation:	Employer:	Employer phone no.:
		( )

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

Members of immediate family that are patients of this office:	

IN CASE OF EMERGENCY CONTACT

Name:	**Relationship to patient:**	**Home phone no.:**	**Cell phone no.:**
		( )	**( )**

INSURANCE INFORMATION

Please complete below and then give your health insurance and prescription benefit card to the receptionist to photocopy for our records.

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

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

Is this patient covered by insurance?	❑ Yes	❑ No	

Please indicate primary insurance					

Subscriber's name:		Birth date:	Group Number:	ID Number:	Co-payment:
		/ /			$

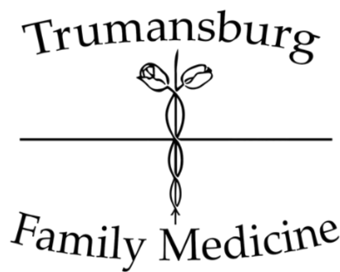
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

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

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

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize TRUMANSBURG FAMILY MEDICINE to release any information required to process my claims.

	Patient/Guardian signature		***Date***	



Patient Demographic Information Questionnaire

This practice is committed to giving every patient the best care, regardless of race, ethnicity, gender identity, sexual orientation, cultural background, language, etc. To support this mission, we ask the following questions for all our patients. ***We ask because we care*** about you and providing the best possible care for you. Your information is confidential. Sharing it is your choice.

Legal Name____

(*the first and last name listed on your insurance*)

Name you want to be called_____________________________

Date of Birth ____

Pronouns

☐ he/him ☐ she/her
☐ they/them ☐ he/him/they/them
☐ she/her/they/them ☐ ze/zim/zir
☐ ze/hir/hirs ☐ Prefer not to answer
☐ Other, please specify: ___________________________

Gender Identity

Select all that apply.

☐ Female/Woman
☐ Male/Man
☐ Neither exclusively male nor female
 ☐ Genderqueer
 ☐ Non-binary
 ☐ Gender non-conforming
☐ Transgender female/Trans woman
☐ Transgender male/Trans man
☐ Not sure/Questioning
☐ Prefer not to answer
☐ Other, please specify: ___________________________

Sex *(What sex is listed on your health insurance?)*

☐ Female ☐ Male
☐ Other, please specify: ___________________________

Sex at Birth *(What sex is listed on your birth certificate?)*

☐ Female ☐ Male
☐ Other, please specify: ___________________________

Ethnicity

☐ Hispanic/Latino/Spanish origin
☐ Not of Hispanic/Latino/Spanish origin
☐ Prefer not to answer
☐ Not sure

Race

Select all that apply.

☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander
☐ Asian ☐ White
☐ Black or African American ☐ Prefer not to answer
☐ Not sure
☐ Another race, please specify: ___________________________

Sexual Orientation

Select all that apply.

☐ Straight or heterosexual ☐ Pansexual
☐ Asexual ☐ Queer
☐ Bisexual ☐ Prefer not to answer
☐ Lesbian or gay ☐ Not sure
☐ Other, please specify: ___________________________

Language

What language(s) do you speak most of the time?

Select all that apply.

☐ English ☐ Burmese
☐ Spanish ☐ Cambodian
☐ Mandarin ☐ Ukrainian
☐ Russian ☐ Korean
☐ American Sign Language
☐ Another language, please specify: ___________________________

Would you like interpretation services?

☐ Yes | ☐ No

If yes, what language? ___________________________________

BILLING POLICY

Payment is expected at the time services are rendered. If your insurance plan requires a copayment we require this to be paid at the time of service. Our billing staff is always available to discuss payment arrangements or answer any questions you may have about your bill.

We are participating providers with many insurance companies. Currently we are participating providers for Medicare, Excellus, Aetna, Cornell Program for Healthy Living, Empire Plan, RMSCO, POMCO, MVP, Cigna, Multiplan/PHSC, Molina Healthcare (formerly Total Care), Fidelis Managed Medicaid and CHP, Blue Choice Option and NYS Medicaid, Today's Options-American Progressive, and other plans. If we participate with your insurance plan we will submit the insurance claim for the services we provide. For all other insurance plans, as a courtesy we will submit your claim to your insurance company on your behalf if you have provided us with the necessary information.

Patients who carry any form of medical insurance should know that all services provided are ultimately the patient's responsibility. Any unpaid balance by your insurance plan is charged directly to the patient, and you are responsible for payment. We cannot render services on the assumption that your charges will be paid by your insurance company. A monthly billing fee of $10.00 will be added to all accounts with a balance that remains unpaid after 30 days. All insurance forms processed by this office, prior to payment in full, are assigned to this practice.

SURESCRIPTS CONSENT

Electronically accessing a patient's medication history allows prescribers to receive critically important information on your current and past prescriptions. With your consent, we can now access your medication history which can include medications prescribed by other providers. Please check your preference below:

_______I CONSENT to give Trumansburg Family Medicine permission to retrieve and use my medication history from Sure Scripts.

_______I DO NOT consent to give Trumansburg Family Medicine permission to retrieve and use my medication history from Sure Scripts.

CONSENT

I consent to examination and treatment by the physicians and nursing staff of Trumansburg Family Medicine. I consent to permit the Trumansburg Family Medicine use and disclose my personally identifiable information for purposes related to my treatment, for purposes related to obtaining payment for my treatment, and for other purposes where Federal law does not require my further Authorization.

____ ____

Name of Patient **Signature of Patient Date**

____ ____

Signature of Personal Representative
Date Signed_____________

Description of Authority to act as
Personal Representative of the Patient

Communication Preferences

Patient Name: ____DOB________________

May our office leave appointment messages? (Please check yes or no)

Home Phone? YES______ NO______ Cell Phone? YES______ NO______
Mobile Text? YES______ NO______ Work Phone? YES______ NO______
With Another person? YES____NO____ Send via E-Mail/ Patient Portal? YES______ NO______

May our office leave messages with medical information? (Please check yes or no)

Home Phone? YES______ NO______ Cell Phone? YES______ NO______
Mobile Text? YES______ NO______ Work Phone? YES______ NO______
With Another person? YES____NO____ Send via E-Mail/ Patient Portal? YES______ NO______

Person(s) authorized to communicate with our office regarding:

_____Appointments Name ____

Relationship____

Phone ____

_____Medical Info Name____

Relationship ____

Phone ____

____ ____________________
Patient Signature Date

____ ____________________
Signature of Patient Representative Date

____
Relationship to Patient