



Your health and well-being are important to us and are our first priority. The following policies are currently in effect:

- Please bring all medication bottles (prescription and over-the-counter supplements) to each and every visit. This will help to improve safety and accuracy.
- All prescriptions for controlled medications (i.e. sleep aids, anxiety medication, pain medication, etc.) are issued for a period of 30-days at a time, there are no additional refills. For all other prescriptions, please allow 24 to 48 hours when requesting refills.
- Patients must call to cancel appointments at least 24 hours prior to the appointment time. If you fail to contact us, you will be considered a no-show. Three consecutive no-shows may result in discharge from the practice.
- Please carefully read the demographic and medications forms given to you at every visit. This is your chance to update all necessary information such as phone number, address, insurance, medication, etc. Bring driver's license, insurance card(s) and co-payment (if applicable) to each and every visit.
- New patients; in order to make your transition seamless we ask that you fill out the record release form to obtain your previous medical record. This form is included in your welcome packet. We will need you to provide your previous Providers name, telephone number, fax number and full address. If you do not have this information our customer service representative will assist you.

Healthcare at Your Fingertips!

We are pleased to provide you with secure, online access to your medical record. By signing up for the AtlantiCare Health-E You Patient Portal, anytime day or night you will be able to:

- Send your provider an electronic message
- Request appointments, medication refills, and referrals
- View your lab and diagnostic test results

When checking in at the office, please provide the front desk staff with your email address so they can register you for your AtlantiCare Health-E portal.

Signing up is easy and free! You may visit the website www.atlanticare.org/patientportal or download the mobile app, [Healow](#).

Thank you for choosing AtlantiCare for all your health care needs.



A MEMBER OF GEISINGER HEALTH SYSTEM

Patient Registration Form

Patient Information:

Reason for visit (if injury how did it occur):

If injury, is it related to: Worker's Comp? Y/N Motor Vehicle? Y/N

Please give date of injury: --/--/---- ___

First Name: _____ Middle initial: _____ last Name: _____

Social Security # _____/_____/_____ Date of Birth: ___/___/___ Age: _____

Sex M/F/T Marital Status (circle one) S M D W Partner

Address _____

City _____ State _____ Zip _____

Home Phone # (____) _____ Cell Phone # (____) _____

Work (____) _____ - _____

Emergency Contact Information (if patient is an adult) or Parent/Guardian Information (if patient is a minor):

First Name _____ Middle Initial: _____ Last Name: _____

Relationship to Patient: _____ Home Phone #: (____) _____

Work Phone (____) _____ Cell phone # (____) _____

Employment Status (circle one) Full-time / Part-time / Self Employed / Retired / Military

Patient's Occupation _____ Work # _____

Employer _____ Address _____

City _____ State _____ Zip _____

Is it okay to leave messages at: Work? Y/N If Student, indicate School _____

Student Status FT/PT

Do you have an Advance Directive? Y/N If no would you like information about it? Y/N



A MEMBER OF GEISINGER HEALTH SYSTEM

Insurance Information:

Name of PRIMARY Insurance _____

If Medicare: Is the patient a Veteran? Y/N Are you currently employed? Y/N

Do you have a Federal Black Lung Card? Y/N Is your spouse/partner currently employed Y/N

Policy / Subscriber # _____ Group # _____

How is the Subscriber related to you? Self / Spouse / Child / Guardian

Policyholder / Subscriber Information:

First Name _____ Middle Initial _____ Last Name _____

Social Security # ____ / ____ / ____ Date of Birth: ____ / ____ / ____ Age: ____ Sex M / F / T

Address _____

City _____ State _____ Zip _____

Home Phone # (____) _____ Cell Phone # (____) _____

Subscriber's Employer _____

Work # (____) _____ Employer's Address _____

City _____ State _____ Zip: _____

Name of SECONDARY Insurance Company _____

Policy / Subscriber # _____ Group # _____

How is the Subscriber related to you? Self / Spouse / Child / Guardian/ Partner

Policyholder / Subscriber Information:

First Name _____ Middle Initial _____ Last Name _____

Social Security # ____ / ____ / ____ Date of Birth: ____ / ____ / ____ Age: ____ Sex M / F / T

Address _____ City _____ St _____ Zip _____

Home Phone # (____) _____ Cell Phone # (____) _____

Subscriber's Employer _____ Work # _____

Employer's Address _____

City _____ State _____ Zip _____

Additional Information

E-mail address _____ preferred method of contact Home / Cell / Email

Is it okay to leave messages at: Home? Y / N Cell? Y / N

Primary Language _____ Country of Origin _____

Translator services required? Y / N

Ethnicity _____ Race _____

Are you visually impaired? Y / N

Are you hearing Impaired? Y / N

Pharmacy Information:

Retail Pharmacy Name: _____

Phone # (____) _____ Fax # (____) _____ Location _____

ID# _____

Mail Order Pharmacy: _____

Phone # (____) _____ Fax # (____) _____

ID # _____

Preferred lab Company:

- AtlantiCare Labs (ACL)
- Lab Corp
- Quest

New Primary Care Physician: _____

Former Primary Care Physician: _____

Referring Physician: _____



Today's Date ____/____/____

Patient's Name: _____ DOB: _____ SEX _____

MEDICAL HISTORY: (please check all that apply)

High Blood Pressure	Drug Abuse
High Cholesterol	Alcohol Abuse
Diabetes	Ulcers
Cancer	Hepatitis
Tuberculosis	HIV
Urinary Tract	Thyroid
Infections	Asthma
Anemia	COPD
Kidney Stones	Stroke
Kidney Disease	Angina
Gallbladder Disease	Lyme's Disease
Heart Disease	Arthritis
Depression	Other (please describe)

Do you have any Allergies to Medication, food or other: Y / N

Surgical History: (please list type of surgery, if any, and date)

Family History: (please check all that apply)

Blood Pressure	Stroke
Diabetes	Heart Attack
Cancer	Kidney Disease
Mental illness	Depression
Other (please describe)	Drug or Alcohol use

Social History

Alcohol: <u>Y / N</u>	If yes, how many drinks are consumed, per week? _____
Cigarettes: <u>Y / N</u>	If yes, how many packs per day? _____
Drug/Substance use: <u>Y / N</u>	

Immunizations

Flu Vaccine _____ TDAP _____ Pneumonia Vaccine _____

Other treating providers: (please list the name and specialty of any other provider currently treating you)

Name: _____ Specialty: _____



Today's Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Please list all medications including vitamins and over the counter supplements and medications

Medication	MG/ Strength	Dose/ How Often

***NOTE:** It is always best to bring in your all medication, supplements and vitamins to all your medical visits.



AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I hereby authorize _____
(Name of health care organization or physician)

To release the health information of:

PATIENT NAME: _____ **Date of Birth** _____

Information is to be released from records pertaining to:

- Ambulatory
- Inpatient
- Emergency Department
- Other _____

For date(s) of service: _____

Specific information to be released:

- Complete Medical Record
- Laboratory tests
- Radiology
- Cardiac tests
- Ophthalmology report
- Other _____

The purpose for this release is for patient treatment.

Information is to be released to:

Information is to be released for the purpose of treatment and continuity of care.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare's compliance with this request. The revocation must be in writing and is subject to terms described in AtlantiCare Notice of Privacy Practices and other AtlantiCare policies.

I understand that I am not required to sign this authorization and that AtlantiCare may not condition treatment or services on my execution of this authorization.

I understand that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protected by HIPAA.

This authorization will expire upon the release of the information described above or one year (12) months after the date of the authorization, unless specified otherwise.

Expiration date: _____

Signature of Patient or Personal Representative Date

Personal Representative's relationship to Patient: _____

Patient is unable to sign because _____

Patient is entitled to a copy of signed authorization.



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the AtlantiCare entity indicated below

<input type="checkbox"/> AtlantiCare Behavioral Health	<input type="checkbox"/> AtlantiCare Health Services
<input type="checkbox"/> AtlantiCare Regional Medical Center	<input type="checkbox"/> AtlantiCare Foundation
<input type="checkbox"/> AtlantiCare Surgery Center	<input type="checkbox"/> AtlantiCare Health Plans
	<input type="checkbox"/> InfoShare

To release the health information of:

PATIENT NAME: _____

DOB _____

To the person or entity listed below:

Recipient's name: _____
 Recipient's address: _____

 Recipient's Phone: _____
 Recipient's Fax: _____

Information is to be released from records pertaining to:

Ambulatory Inpatient Emergency Department

Other _____

For date(s) of service: _____

Specific information to be released:

Complete Medical Record Laboratory tests Radiology Cardiac tests

Other: _____

Information is to be released for the purpose of: _____

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations. I understand that I have the right to revoke this authorization at any time prior to the requested entity's compliance with request. The revocation may be subject to the entity's Notice of Privacy Practices and other policies.

I understand that I am not required to sign this authorization and that AtlantiCare may not condition treatment or services on my execution of this authorization.

I understand that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protect by HIPAA.

This authorization will expire upon the release of the information described above or 6 months after the date of the authorizations, unless specified otherwise: Expiration date: _____

Signature of patient or personal representative: _____ Date: _____

Personal representative's relationship to patient _____
 Patient is entitled to a copy of signed authorization.



Consent to discuss Care & Treatment

Patients Name: _____ Birthdate: ____/____/____

Practice Name _____ Primary Provider _____

I permit the following information to be discussed with the following family member, friend or others person or persons listed below.

I understand that if I want any of the persons listed below to receive a copy of my records; I must complete and sign a separate authorization form.

In an emergency or if I am admitted to the hospital and unable to make my wishes known, I understand that my provider and hospital staff may rely on the above permissions to determine with whom they may discuss my care.

I can change the permissions stated below at any time by notifying my provider or AtlantiCare's Privacy office.

- Appointments only
- Results/ Plan of care _____
- My bill Name Relationship Phone

- Appointments only
- Results/ Plan of care _____
- My bill Name Relationship Phone

- Appointments only
- Results/ Plan of care _____
- My bill Name Relationship Phone

Patient signature _____ Date _____

Print name _____

Signature of lawful personal representative* _____ Phone _____

Print name _____

*Required only if the patient is a minor or unable to represent self.