Account#_____

D. JOEY BARRIOS III MD
GENERAL SURGERY

Patient Registration Form

PATIENT INFORMATION **DATE: _____**

Patient First Name: _____ **Last**: _____**MI**: _____

Birth Date: _____/_____/_____ **Social Security#** _____-_____-_____

Address: _____
Street **City** **State** **Zip Code**

Home phone # (_____)_____ **Cell #** (_____) _____**Email**_____

Primary Language: ☐ English ☐ French ☐ Spanish ☐ Other **Ethnicity**: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Decline to Respond

Race: ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Other:_____ ☐ Decline to respond

Place of Employment: _____ **Work #** (_____) _____ext_____

RESPONSIBLE PARTY INFORMATION (PERSON WHO WILL RECEIVE ANY CORRESPONDENCE FROM OUR OFFICE)

Responsible Party's Name: _____ **Relationship to patient**: _____

Address (if different from patient): _____
Street **City** **State** **Zip Code**

Home phone # (_____)_____ **Work #** (_____)_____ **Cell #** (_____)_____

Place of Employment: _____ **Phone**: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Policy Holder's Name: _____ **Relationship to patient:** _____

SSN*: _____-_____-_____ **DOB***:_____/_____/_____ **Place of Employment*:** _____

Secondary Insurance Carrier: _____

Policy Holder's Name: _____ **Relationship to patient**: _____

SSN*: _____-_____-_____ **DOB***:_____/_____/_____ **Place of Employment*:** _____

EMERGENCY CONTACT: _____ **Relationship to Patient:** _____

Home Phone: (_____)_____ **Other Phone: (_____)**_____

Who can we thank for referring you to our office?

☐ Family/Friend: _____☐ Physician-name _____☐Other: _____

MEDICAL RELEASE

I authorize the release of medical information concerning me to be released to the physician listed. The information that can be released includes all medical records, lab reports, photographs, and insurance coverage. A copy of this form is as good as the original. I hereby release you from all legal liability that may arise from the release of the information requested. I will assume responsibility for any fee that may be incurred due to this request.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Dave J. Barrios, III, MD, APMC's Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law.

PATIENT DISCLOSURE OF OWNERSHIP INTEREST

Dave J. Barrios, MD may issue orders for you to receive treatment at Park Place Surgical Hospital. In accordance with La R.S. 37:1744 and 42 CFR 489.20, please be advised that the physician has an ownership interest in that facility. If you have any questions about receiving care at Park Place Surgical Hospital, or objections to receiving treatment at Park Place Surgical Hospital, please let a nurse or your physician know before any steps are taken by our office or Park Place Surgical Hospital in connection with your treatment.

Patient Signature: _____ Date: _____

Patient Print Name: _____

Witness Signature: _____

*If the subject of information is a minor, or is an incapacitated patient, the parent or guardian must sign.
If the subject of information is deceased, the personal representative or next of kin must sign.

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