Highland Ob / GYN Clinic, P.A.

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2301 Robeson Street, Suite 201
Fayetteville, NC 28305
Phone: (910) 485-1191 / Fax: (910) 485-6006

Patient Registration Form

Patient Name: ____ Spouse/Significant Other Name: ______________________________________

Patient Birthdate: _____________________________________ Spouse Birthdate: _____________________________________

SSN: ____ Spouse SSN: ____

Employer: ______________________________________ Spouse Employer: ____________________________________

Occupation: _____________________________________ Spouse Occupation: ___________________________________

Work Phone: ____________________________________ Spouse Work Phone: __________________________________

Cell Phone: _____________________________________ Spouse Cell Phone: ____________________________________

Street Address ____ Rt.___________________ Box______________

City____ State_________ Zip___________ Patient's Driver's Lic. # _______________

Circle one: Married Single Widow Divorced Separated

Race: _____________________

Patient consent for message reminders for you on your: Cell phone: ______ Home: _______Work:_________ (Please initial beside indication)

Patient PCP Name: __________________________________ Referring Physician: ____________________________________

I am _______ I am not________ allergic to any medications. If any please list. ____

Pharmacy Information: ____________________________________ ____

(Name) (Address)

Name, Address, Phone # of Emergency Contact (if different than above)

Name ____ Home Phone # _________________ Work Phone #_________________

Address____ City_____________________

State______ Zip______________

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Please present your current insurance card at check in. Your insurance contract is an agreement between you and your insurance
company. As a service to you, we will file with your insurance carrier. You are responsible for payment of deductibles, copayments,
and any non-covered service, at the time of service.

Primary Insurance C:.____ Phone #_________________________________
Insurance Claims Address:
____
Subscriber's Name: ___________________________________ ID#____________________________ Group #_____________________
Subscriber's DOB: __________________________ SS#______________________ Place of Employment________________________
Secondary Insurance Co:____ Phone #
____
Insurance Claims Address:
____
Subscriber's Name: ___________________________________ ID#____________________________ Group #_____________________
Subscriber's DOB:__________________________ SS#______________________ Place of Employment
____

******PLEASE CHECK YOUR METHOD OF PAYMENT FOR TODAY'S VISIT******

Cash__________ Check Number__________ Debit Card__________ MasterCard__________ Visa__________
Discover__________ American Express__________

Authorization to release information / to pay benefits to Highland OB/GYN Clinic, PA. I hereby assign payment directly to the designated
provider for any medical/surgical procedures performed. I agree to be responsible for payment of services determined by my insurance
carrier as not medically necessary or noncovered service. I agree that this authorization shall be valid until rescinded in writing or replaced
by one of a later date.

____ ____

Patient Signature **Date**
(If patient is a minor, Parent/Guardian Signature)
Prescription Consent

EPrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the office. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. EPrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include: Formulary and benefits transactions-Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events. Fill status notification- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled. By signing this consent form you are agreeing that Highland OB/GYN Clinic, PA can request and use your prescription medication history from other healthcare providers and /or third party pharmacy benefit payors for treatment purposes.
I understand all of the above; I hereby provide informed consent to Highland OB/GYN Clinic, PA to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

____ ___________________________________

Patient's Signature **Date**

HIPPA Information

I have been given a copy of the Highland OB/GYN Clinic Notice of Privacy Practice, version effective 6/1/2011. I consent to the uses and disclosures of my health information as outlined in the notice.

____ ___________________________________

Patient's Signature **Date**