Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
First Name Used:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Legal Sex: Assigned Sex at Birth:
Gender Identity: Male____ Female____
Transgender Male____ Transgender Female____
Gender Non-conforming____ Self Identify_____
Sexual Orientation: Heterosexual____ Homosexual____
Bisexual____
Other____ Do Not Know____ Choose Not To Disclose____
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language: Race:
Ethnicity: **Relationship Status:**

Guarantor Information (to whom statements are sent)

Name:
Address:
Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone: **Mobile Phone:**

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by:
Primary Care Provider:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:
Crossroads:
Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Gender on Insurance (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Gender on Insurance (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

ACKNOWLEDGEMENT AND AUTHORIZATION:

- Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more full described in Des Moines University's Notice of Privacy Practices (NPP). Des Moines University is permitted to revise its NPP at any time. We will provide you with a copy of the revised NPP upon your request.

By signing below, you are acknowledging that you have received a copy of Des Moines University's Notice of Privacy Practices

Signed_____ **Date:**_____

- I understand that I am financially responsible to pay Des Moines University it's usual charges for all services received through Des Moines University, including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Des Moines University, and direct that payment of proceeds be made directly to Des Moines University.

- I authorize the release of medical record information or excerpts thereof to any insurance company or third party payor for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization, per HIPAA regulations.

- I authorize Des Moines University Clinic to obtain/have access to my medication history.

- I authorize the healthcare providers of DMU Clinic to administer treatment as deemed necessary for my care. As a teaching institution, students may be involved in my care. I certify that no guarantee has been made as to the results that may be obtained from the treatment. This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Signed_____ **Date:**_____

Medicare Secondary Payer Questionnaire: To be completed by patients who present with Medicare insurance products.

1. Do you have any group health insurance coverage based upon your current or former employment? Yes ____ No ____

2. Do you have any group health insurance coverage based upon your spouse or other family member's current employment? Yes ____ No ____

3. Are you receiving any of the following benefits?

Black Lung	Yes ____	No ____
Veterans Administration	Yes ____	No ____
End Stage Renal Disease	Yes ____	No ____

4. Is this service related to an automobile injury or illness? Yes ____ No ____
Is this service related to a work-related injury or illness? Yes ____ No ____
Is this service related to any other third party liability injury or illness? Yes ____ No ____

If you have answered yes to any of the above questions, we will request further benefit information.