Northport Comprehensive Care

Affiliated with The Huntington Heart Center
325 Main Street, Northport, NY 11768
Phone: 631-230-2030 Fax: 631-423-2306

PATIENT REGISTRATION

**** PLEASE WRITE CLEARLY * USE BLACK OR BLUE INK ONLY ****

Name: _____

Date of Birth: _____/_____/_____ **Sex:** _____

Address: _____ **City:** _____ **Zip:** _____

Home: ( ) _____-_____ **Cell:** ( ) _____-_____ **Work:** ( ) _____-_____

E-mail address: _____

Primary Care Physician: _____ **PCP Phone:** ( ) _____-_____
*** PLEASE PROVIDE FIRST & LAST NAME OF PRIMARY CARE DOCTOR ***

Emergency Contact: _____ **Phone:** ( ) _____-_____

Please read and check the statements below:

☐ I have read and understand the Notice of Privacy Practices. I understand that The Huntington Heart Center will not disclose my protected personal health information to anyone that I have not personally authorized.

☐ I understand that I will be held liable for payment of all services rendered to me by my physician at the Huntington Heart Center if I have provided incorrect insurance information which results in non-payment on any date of service. I understand there are cancellation & a no show charge of $25 if I do not inform the office within 24 hours of my appointment. The fee for cancellation & no show for Thallium Stress Test is $200 and the fee for PET scans is $500 unless there is an emergency.

Patient Signature: _____ **Date:** _____

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Last Name: _____ First Name: _____ DOB: ____/____/_____

I, _____(do____/do not_____) give permission for any staff member of the **NORTHPORT COMPREHENSIVE CARE, affiliated with The Huntington Heart Center,** and its Physicians, to speak with a family member or individual regarding appointments, prescriptions, financial matters, test results, or pick up records and films on your behalf.

Please list the individuals that we may speak with:

Name: _____ Relationship: _____ Phone #: ( ) _____-_____

Name: _____ Relationship: _____ Phone #: ( ) _____-_____

Name: _____ Relationship: _____ Phone #: ( ) _____-_____

May we leave a voicemail recording regarding your appointment or a message to call us back?

YES _____ NO_____

Authorization for Release of Information via E-mail

By providing your e-mail address, you agree to receive information about your protected health information as well as upcoming appointments that are scheduled.

YES_____ NO_____

Authorization to Access Prescription History

I hereby authorize my physician(s), to download my prescription history through computer networks operated by Surescripts Clearinghouse, a provider of electronic prescribing services, in connection with providing my health care services.

YES_____ NO_____

Authorization for Release of Information/Assignment of Benefits

I hereby authorize and direct my physician(s), having treated me, to release to other treating physicians, insurance carries, government agencies, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to my physician(s), sufficient monies and/or benefits I may be entitled from government agencies, insurance carries and others who are financially liable for medical costs of the care and treatment rendered to me or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

Signature: _____ Date: _____

I have read & understood the HIPAA Notice of Privacy Practices of the Huntington Heart Center. I understand how the practice will handle my personal health information.

Signature: _____ Date: _____

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Name: _____ **DOB:** _____ **Date:** _____

Approximate Height: _____ **Approximate Weight:** _____

Of the languages below, please indicate/circle the ONE that you prefer:

●English ●Spanish ●Other: _____

Of the choices below, circle which ethnicity best describes you:

●Hispanic/Latino ●Non-Hispanic/Latino ●Neither Choice Applies

Of the choices below, circle which race(s) best describes you:

●American Indian/Alaskan Native ●Asian ●Black/African American ●Native Hawaiian/Other Pacific Islander

●White/Caucasian ●Other: _____

Do you have any known drug allergies? Circle all that apply:

●No Known Drug Allergies ●Ace Inhibitors ●Aspirin ●Codeine/Other Opiates ●Erythromycins

●VP Dye/Iodine Containing ●NSAIDS/Ibuprofen/Aleve ●Penicillin ●Sulfa Drugs ●Tetracycline

●Other _____

Cigarette smoking history, please circle which best describes you:

●Current everyday smoker ●Current occasional smoker ●Former smoker ●Never smoked

Please list prescription medications and dosages:

● _____ ● _____

● _____ ● _____

● _____ ● _____

Pharmacy(s) name and address:

● _____

● _____

● _____