



997 Old US Hwy 70W, Suite A
Black Mountain, NC 28711
Phone: 828.298.7981
Fax: 833-449-4170

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION					
First Name:	MI:	Last Name:	Age:	Date of Birth:	Gender: Male ___ Female ___ Prefer Not To Answer ___
Ethnicity: Hispanic ___ Not Hispanic ___ Refused ___		Language Spoken: English ___ Spanish ___ Other ___		Race: White ___ Asian ___ African American ___ Hispanic ___ Indian/Native ___ Other ___	
Marital Status: Single ___ Married ___ Widowed ___ Divorced ___			Social Security Number:		
Mailing Address:					
City:		State:		Zip Code:	
Home Phone:		Cell Phone:		Email:	
Occupation:		Employer:		Work Number:	
Preferred Pharmacy:					
INSURANCE INFORMATION					
Primary Insurance:			Policy Number:		
Name as it appears on card:			SSN of Policy Holder (required):		
DOB of Policy Holder (required):			Group Number:		
Patient Relationship to Policy Holder: Self ___ Spouse ___ Child ___ Other ___					
Parent/Guardian (Required if Patient is under 21 Years Old) NOTE: By law, both parents can be held responsible for medical bills for minors; a medical practice is NOT bound by any separation agreement, divorce, or child support order.					
Parent/Guardian:		Date of Birth:		Social Security Number (required):	
Address (if different from above):					
Employer:			Preferred Phone Number:		
EMERGENCY CONTACT INFORMATION					
Name:		Relationship to Patient:		Phone Number:	

By signing, you agree that the information above is correct and allow East Asheville Family Health Care to file claims on your behalf.
HIPAA CONSENT: Without a signed consent, we CAN NOT share information regarding your medical care (including family). Please list anyone you would like to have this information below.

1. _____

2. _____



No Show and Cancellation Agreement

East Asheville Family Health Care's goal is to provide excellent care in a timely manner. Providing the best care requires attending all appointments, but in the event an appointment must be changed, it is important to do so as early as possible so we may schedule other patients in open slots.

- Whenever possible, I shall provide at least 72 hours' notice if I need to change or cancel an appointment. I understand that not doing so may impact patients on the waiting list who are unable to use my time slot.
- I understand that multiple reminders by phone and email serve as opportunities for patients or caregivers to confirm, cancel, or reschedule an upcoming appointment.
- I understand that missing or rescheduling an appointment without notifying our office at least 48 hours prior to the appointment time will result in a \$50 fee.
- I understand that rescheduling an appointment may result in a delay in scheduling my next appointment.
- I understand that repeated no-shows may result in dismissal from the practice.

Emergencies occur, such as hospitalization of a patient or caregiver, car accident, or other unavoidable situations, yet I will make every effort to keep my appointment slot. Missed appointments are reviewed on an individual basis.

I understand and agree to the above No Show and Cancellation Agreement.

Printed Patient Name: _____ Patient DOB: _____

Responsible Persons Name (if not patient):

Patient or responsible person signature _____ **Date:** _____



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Authorization to Release Health Information

Patient Information

Name _____ D.O.B _____

Address _____

City _____ State _____ Zip _____ Phone _____

I _____ am allowing _____
(name of facility *not our office*)

to release the following information to **East Asheville Family Health Care** :

- ☐ Entire Record
- ☐ Labs
- ☐ Diagnostic Studies
- ☐ Office Visit Notes

Please fax the records to our office as soon as possible. Thank you!

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by state/federal law.
- I may refuse to sign this authorization.
- I understand released information may include a communicable disease diagnosis such as HIV.

Patient Signature _____ Date _____

- ☐ I have obtained verbal consent from the patient to receive these records.