

Immigration Registration Form

Patient Information	Name (Last, First, MI)					Today's Date		
	Street Address							
	City			State	Zip	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age
	Social Security #			Home Phone ()		Work Phone ()		
	Alternate Phone Where You Can Be Reached ()				Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
	Email Address							
	Occupation	Employer		Work Email Address				
Immigration Information	File Number (A Number)							
	Passport Number							
Use and Disclosure of Protected Information	<p>Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. An example would be if we refer you to a specialist, we might provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS).</p> <p>Federal Law provides that we may use your medical information to obtain payment for your services without further specific notice to you, or written authorization by you. For example, under your health plan we are required to provide them with a diagnosis code for your visit and a description of the services rendered.</p> <p>Federal Law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. Examples of this are: 1) our accountants may see your name, dates of treatment and procedure codes during audits of our books or 2) We may use your information for financial services, quality assurance, risk reductions and claims management purposes with our medical professional liability insurer. We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:</p> <ol style="list-style-type: none"> 1) Required by law 2) Required for public health purposes 3) Required by law to report child abuse 4) Required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct 5) Required by law in judicial or administrative proceedings 6) Required for law enforcement purposes by a law enforcement official 7) Required by coroner or medical examiner 8) Permitted by law to a funeral director 9) Permitted by law or organ donation purposes 10) Permitted by law to avert a serious threat to health or safety 11) Permitted by law and required by military authorities if you are a member of the armed forces of the United States. <p>Uses or disclosures of your medical information will be made only with this written authorization as needed to complete insurance billing or to give medical information for specialist referral purposes. You have the right to revoke this written authorization.</p>							
	Print Name: _____ Date: ____ / ____ / ____							
	Signature: _____							