CARE POINT
Health & Wellness Center

PATIENT REGISTRATION

Patient Information

First _____ Middle Initial _____ Last _____ Date _____

Date of Birth _____ Social Security # _____ Driver's License # _____

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

I give my permission for Care Point to call/text me on my cell phone and leave messages. ☐ Yes ☐ No

Email:_____ Patient is: ☐ Responsible Party ☐ Policy Holder

Sex: Female ☐ Female ☐ Male ☐ Transgender

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed

Student Status: ☐ Full Time ☐ Part Time ☐ NA Preferred Pharmacy:_____

Insurance Information

Name of Insured:_____Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insurance:_____

Employer Name:_____Employer ID#:_____

Insurance ID#_____Medicaid ID#_____

If Bend Bend Cares client, name of Case Worker:_____

How did you hear about Care Point?_____Language:_____

Financial Policy and Insurance Authorization

I hereby authorize and direct the above named dental practice to release to government agencies, insurance carriers or others who are financially liable for my dental care all information to substantiate payment for such dental care and to permit representatives thereof examine and make copies of all records relating to such care treatment and I hereby assign, transfer and set over to the above named dental practice sufficient monies and/or benefits to which I am entitled from government agencies, insurance carriers or others who are financially liable for my dental care to cover the costs of the care and treatment rendered to myself or my dependent in said practice.

Patient Signature:_____Date:_____

Authorization for Release of Medical Information

Please forward copies of requested records to:

Care Point Health & Wellness Center
2200 South Monroe Street
Tallahassee, FL 32301

O: (850) 354-8765
F: (850) 900-5941

Release the following:

_____Entire Health Record
_____Immunization Records Only
_____Specific Dates of Treatment: From:_____To_____

_____Other_____

Please forward copies of medical records from

_____

_____

_____

I authorize Care Point Health & Wellness Center to search and secure any records on the Health Information Exchange Network (HIE) ☐ Yes ☐ No

I am requesting that this protected health information be released for the following reason: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

☐ This request is being made because I am transferring care to another provider or leaving the area.

☐ This authorization shall remain in effect until_____(up to 6 months) at which time this authorization expires.

☐ I also authorize for the release of information regarding assessment, diagnosis and treatment of alcohol and/or substance abuse.

☐ I also authorize for the release of information regarding diagnosis and/or treatment of AIDS or HIV.

I understand that I have the right to revoke this authorization, in writing, at an time by sending a written notification to Care Point Health & Wellness Center at the above address.

I hereby authorize Care Point Health & Wellness Center to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

Patient Name:_____Date of Birth:_____

Patient Signature:_____Date:_____

Legal Guardian:_____Relationship:_____

Legal Guardian Signature:_____Date:_____

Care Point Witness Signature:_____Date:_____

HIE Participation informed consent

This organization participates in a Health Information Exchange (HIE) to facilitate the care of our patients. Your records may be shared with your other providers that declare provider relationships with you via phone, fax, or HIE. You may decline to participate in HIE by going to https://secure.fl.hienetworks.com/PatientOptOut.aspx and following the directions.