NORTHWEST Geriatrics

Facility Name: _____

(Leave blank if the home is a Private Residence)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____**Fax:** _____**Patient's Room** _____

Patient Information

Name: _____

Social Security Number: _____ Gender: (circle one) M / F

Date of Birth: _____

Medicare Number (include suffix): _____

DSHS Patient Identification Code (PIC): _____

Secondary Insurance _____

If the patient has a HMO such as Medicaid/Molina/United HealthCare/WAHLOP/WA Apple Healthcare) we **cannot enroll or see the patient** until the family calls the insurer and assigns our provider as the named **Primary Care Provider.**

Please attach copies of ALL patient insurance cards (including Medicare).
We cannot process your registration form without correct insurance information.

Additional Contact / Responsible Party / Emergency Contact Information

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Work/ Cell Phone: _____

Does this person have medical **Power of Attorney**? (Circle One): Yes No

Is this person the **financially responsible party**? (Circle One): Yes No

NORTHWEST Geriatrics

Patient Name: _____

Date of Birth: _____

Authorization to Treat Patient Statement

Be it known that I have chosen Northwest Geriatrics to provide my primary medical care. I live at the address given on the previous page, and this is my private residence. I intend to, or have lived at this location for longer than six months, and I have no other place that is my home. Further, I hereby authorize other medical and mental health professions and institutions to release to Northwest Geriatrics copies of all Records deemed necessary to provide me with medical care. I give specific consent to release information relating to drug and alcohol abuse, mental health and psychiatric disorders, STDs, and HIV or AIDS Virus. Further, I authorize Northwest Geriatrics to release copies of my medical records to other medical and mental health professionals when appropriate and related to the matter at hand. This release includes the use of an electronic medical record to other sources of medical care, such as pharmacies, etc. Patient information is regulated and protected by HIPAA standards.

The signature below authorizes Northwest Geriatrics to treat me.
I certify that I am competent to make this choice and these authorizations. I also certify that all the information I provided in this document is true and correct as of the date below.

If I am not the patient, the signature below certifies that I am the legally appointed guardian of the individual named on the previous, and I make this choice and these authorizations on his or her behalf.

Further, in my power as the guardian/durable power of attorney of _____ (patient), I authorize and consent to routine and emergency medical treatment for the patient when deemed necessary by qualified medical personnel.

This authorization is being given in advance of any specific treatment required and I waive my right of prior informed consent to such treatment. This authorization shall remain effective unless revoked in writing by me.

Patient/Guardian's Signature & Date: _____

Relationship:_____

Is the patient Full Code (Resuscitate) or No Code (Do Not Resuscitate)? (Circle One)