New Patient Registration Form

Cleo Baruiz MD PA
2424 SW Cary Parkway
Cary, NC 27513

IDENTIFICATION

Last Name:	First Name:
Middle Name:	Nickname:
Suffix:	Pervious Last Name:

Legal Sex: ☐ M ☐ F | DOB: M M / D D / Y Y Y Y | SSN: _ _ _ - _ _ - _ _ _ _

CONTACT

Address:		
City:	State:	ZIP Code:

Home Phone: _ _ _ - _ _ _ - _ _ _ _	Email Address:
Mobile Phone: _ _ _ - _ _ _ - _ _ _ _	Contact Preference: ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Mail ☐ Portal
Work Phone: _ _ _ - _ _ _ - _ _ _ _	
How did you hear about us?	
Emergency Contact Name:	
Emergency Contact Phone:	Emergency Contact Relationship:
Next of Kin Name:	
Next of Kin Phone:	Next of Kin Relationship:

DEMOGRAPHICS

Language:	Pronouns: ☐ she/her ☐ he/him ☐ they/them ☐ Prefer not to specify

Race:	Ethnicity:
Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced ☐ Unknown	Assigned Sex at Birth: ☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose
Sexual Orientation: ☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Other, specify below ☐ Choose not to disclose	Gender Identity: ☐ Identifies as Male ☐ Identifies as Female ☐ Transgender Male/Female-to-Male (FTM) ☐ Transgender Female/Male-to-Female (MTF) ☐ Gender non-conforming ☐ Other, specify below ☐ Choose not to disclose
Other comments:	
Employer Name and Occupation:	
Industry:	Date of Retirement (if applicable):

INSURANCE AND PHARMACY

*Please be prepared to present insurance card(s) to the front desk.		
Primary Insurance Name:	Secondary Insurance Name:	
Who should receive billing statements (Guarantor)? ☐ Self ☐ Other:		
Guarantor Name:		
Patient's Relationship to Guarantor:	Guarantor Date of Birth:	
Billing Address:		
City:	State:	ZIP Code:
Pharmacy Name and Location:		
Pharmacy Telephone:		

PRIVACY

Private Messages from Doctor or Staff

Should home/work phone messages include only our office number (919-467-3275)?	☐ Yes ☐ No
Should home/work phone messages include doctor's name (Dr. Baruiz)?	☐ Yes ☐ No

Automated Messages from Office

	Email	Phone	Text Messages	
Health Notifications	☐	☐	☐	
Appointments*	☐	☐	☐	*highly recommended
Announcements	☐	☐	☐	
Billing	☐	☐	☐	

Health Data Sharing

Patient Record Sharing: I give permission to Cleo Baruiz MD PA to share and receive my medical records with my providers at connected care locations.

Patient Signature (please print and sign) Date

____ ____/____/_______

Are there any care locations that would like to explicitly EXCLUDE from sharing and receiving your medical records?
List here:

Medication History Sharing: I give permission to Cleo Baruiz MD PA to obtain my medication history from pharmacies I have used in the past to enable automatic updates of my electronic health records.

Patient Signature (please print and sign) Date

____ ____/____/_______

PRIVACY, BILLING, AND CANCELLATION NOTICES

I have read the Notice of Privacy Policy which is available on our website, www.CleoBaruizMD.com and at the front desk.

Patient Signature (please print and sign) Date

____ ____/____/_______

Assignment and Release: I assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directory for recommended services performed that are not covered under the terms of my health plan. I authorize Cleo Baruiz MD to release any medical information required to process my claims.

Patient Signature (please print and sign) Date

____ ____/____/_______

I have read the Notice of Financial Policy which is available on our website, www.CleoBaruizMD.com and at the front desk.

Patient Signature (please print and sign) Date

____ ____/____/_______

I understand that if I must cancel my scheduled appointment for any reason, I must give **24 hours advance notice for office visits and 72 hours advance notice for annual physical check-ups** by calling our office at (919) 467 2245 during business hours.

I understand that I may be charged a cancellation fee if I do not provide the required advance notice and may be charged an administrative fee of $25.00 for office visits and $50.00 for annual physical check-ups.

Patient Signature (please print and sign) Date

____ ____/____/_______