TANSINDA MEDICAL ASSOCIATES

JAMES N. TANSINDA, M.D.

PATIENT REGISTRATION

Name_____ SS#_____-_____-_____
Street Address _____DOB_____MS: S M W Sep D(circle one)
City _____State_____ZIP_____
Tel# Home_____Office_____
Spouse's Name_____
Spouse's Employer/Address_____
Emergency contact Name_____Tel#_____ Relationship ____ _____

PATIENT EMPLOYER INFORMATION

Employer Name_____Tel#_____
Employer Street Address_____City_____State_____Zip_____
Patient Occupation _____

INSURED PERSON (if not patient)

Name_____Tel#_____
Street Address _____City _____State_____Zip_____
Relationship to patient_____

INSURANCE

Medicaid # (if applicable)_____Medicare # (if applicable)_____
Primary Insurance Company Name _____
ID #_____Group#_____Tel#_____
Seconday Insurance Company Name_____
ID#_____Group# _____Tel#_____

INFORMATION and ASSIGNMENT of BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authoriztion to be used in place of the original.

Date_____**Signature**_____

I hereby authorize Dr. James N. Tansinda to apply for benefits on my behalf for covered services rendered by him, or his order. I request that payment from my insurance company be made directly to Dr. James N. Tansinda (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date_____**Signature**_____
(patient, parent. or guardian)

3455 Wilkens Ave. Baltimore, Maryland 21229 Phone# 410-800-2948 Fax# 410-800-2956

Patient Consent For Use and Disclosure of Protected Health Information

With my consent, James Tansinda, M.D. may use and disclosure protected health information (PHI) about me to carry out treatment, payment, and healthcare operation (TPO). Please refer to James Tansinda, M.D. notice of privacy practices for a more complete description of such uses and disclosures. I have the right to review the notice of privacy practices prior to signing this consent. A revised notice of privacy practices may be obtained by forwarding a written request to James Tansinda, MD at 3455 Wilkens Ave. Suite 204, Baltimore, Maryland. 21229.

With my consent, James Tansinda, MD may call my home or other designated location and leave a message on a voice mail or with a person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and all calls pertaining to my clinical care, including laboratory results among others.

With my consent James Tansinda, MD may mail to my home or other designated location any items that assist in TPO, such as reminder cards and patient statements as long as they are marked *Personal and Confidential*

With my consent, James Tansinda, MD may mail my appointments and reminder cards and patient statements. I have the right to request that James Tansinda, MD restricts how it uses or discloses my PHI to carry out TPO. However, the practices is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to James Tansinda, MD use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except that the practice has already make disclosures in reliance upon my prior consent. If I do not sign James Tansinda, MD may decline to provide treatment to me.

Date_____

_____

Print Patient Name or Legal Guardian

_____

Patient Signature or Legal Guardian

Health Care Advance Directive

In the event I am unable to communicate my health care decisions I appoint the following person as my decision maker:

Name: _____

Address: _____

_____

Phone: _____ Relationship: _____

If I am in a condition from which I am not expected to live or recover, I would like to state whether I want the following life sustaining treatments: (please initial)

Ventilator (Breathing Machine):	YES _____	NO _____
Intravenous Fluids:	YES _____	NO _____
Artificial Feeding Tube:	YES _____	NO _____
Blood Transfusions:	YES _____	NO _____
Kidney Dialysis:	YES _____	NO _____
CPR	YES _____	NO _____

OR

I would prefer to have my decision maker decide on my behalf:(please initial) _____

My signature below attests that I understand the purpose of this document:

My Signature: _____

Print Name: _____

My Address: _____

_____

My Phone #: _____ Date: _____

Witnesses: *(not me or my appointed decision-maker)*

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone #: _____ Phone #: _____

Signature: _____ Signature: _____

The above have witnessed my signature and to the fact that I appear to be of sound mind. They are not responsible in any way for me financially or medically.

Name:_____ DOB:_____

Patients Email:_____

Race & Ethnicity:

Select a race:
__ American Indian/Alaska Native
__ Asian
__ Black/African American
__Native Hawaiian or Other Pacific Islander
__White
__ Other
__Decline

Sexual Identification:

Select a sexual identification:
__Straight or heterosexual
__lesbian, gay, or homosexual
__Bisexual
__Something else, please describe
__ Don't know
__ Decline

Gender Orientation:

Select a gender orientation:
__Male
__Female
__Transgender male/Trans man/Female-to-male
__Transgender female/Trans woman/Male-to-female
__Genderqueer, neither exclusively male nor female
__Additional gender category/(or other), please specify
__ Decline

Language Preference:

Select a language preference:

___ English __Decline
__Spanish
__Other