Erik Sloman-Moll MD PA
Patient Registration Form

Patient Information

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Age: _____

Gender: Male or Female Marital Status: Single Married Widowed Divorced

Ethnicity: Hispanic or Non-Hispanic other Preferred Language: English Spanish Other:_____

Race: White Black/African Amercian Asian American Indian Hawaiian Other Pacific Islander

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone Number: (___)_____ Cell Number: (___)_____

Emergency Number: (___)_____ Work Number: (___)_____

EMAIL:_____ Pharmacy_____
Patient Employed: Yes or No Name of Employer: _____
If your visit is injury related, where did the injury occur? Work Home Other: please specify_____
Referring Physician Name: _____

Primary Insurance Information
Insurance Name: _____ ID Number: _____
Insured Party Name: _____ Date of Birth: _____
Social Security Number:_____ Relationship to Patient: _____
Secondary Insurance Name:_____ ID Number: _____

Guardian- If Patient is a minor, please complete the following:
Name:_____ Date of Birth: _____
Relationship to Patient:_____ Social Security Number: _____
Home Address: _____ City:_____ State: _____ Zip Code:_____
Home Phone: (___)_____ Cell Number: (___)_____
Name of Employer: _____ Work Number: (___)_____

I authorize Erik Sloman-Moll MD PA to submit a claim to my medical insurance carrier or its intermediaries for all covered services or products provided by the practice. I understand that I am responsible for any deductible, co-insurance, co-payment, and any non-covered services. I understand that it is policy of the practice to collect for these at time of service. I understand that it my responsibility to confirm my provider is an in-network provider and update my insurance file whenever I change insurance carriers. I understand that failing to provide current information will make me immediately responsible for balances otherwise paid by my medical carrier. I understand that if I join an HMO, I will inform the practice prior to scheduling any appointment so staff can identify my eligibilty for care with this practice. I understand appointments are pre-arranged and it is my responsibility to keep my appointment or cancel my appointment with a minimum 24-hour notice. Failure to cancel will result in a $25 cancellation fee. I have completed the above information an certify that it is true and correct to the best of my knowledge. I will notify this office of any change in my health status of the above information.

Patient/Guardian Signature:_____ ***Date of Signature:***_____

Erik Sloman-Moll MD PA

Forma de Registro

Informacion del Paciente

Nombre: _____ Fecha de nacimiento: _____

Numero de Seguro Social:_____ Edad: _____

Sexo: Masculino o Femenino Estado Civil: Soltero Casado Viuda(o) Separado Divorciado

Etnico: Hispano(a) o No Hispano Lenguaje: Ingles Espanol Otro:_____

Raza: Blanco Aficano Asiatico Otro:_____

Direccion:_____Ciudad: _____ Estado: _____ Codigo Postal: _____

Telefono de Casa: (___)_____ Telefono de Celular: (___)_____

Telefono de Emergencia: (___)_____ Telefono de Trabajo: (___)_____

EMAIL:_____Farmacia_____
Paciente Empliado Por:_____
Si su visita es relacionado a un accidente, donde ocurrio su accidente? En casa trabajo otro_____
Nombre de Doctor que lo referio: _____

Aseguranza Primaria

Nombre de Aseguranza: _____Numero de Identificacion:_____
Nombre de Persona Asefurada: _____ Fecha de Nacimiento: _____
Numero de Seguro Social:_____ Relacion al Paciente:_____
Nombre de Aseguranza Secundaria:_____Numero de Identificacion: _____

Guardian- Si el paciente es menor de edad, por favor llene lo siguiente:

Nombre: _____ Fecha de Nacimiento: _____
Relacion al Paciente: _____ Numero de Seguro Social: _____
Direccion: _____Ciudad: _____ Estado: _____ Codigo Postal: _____
Telefono de Casa: (___)_____ Telefono de Celular: (___)_____
Nombre de Empliado: _____ Telefono del Trabajo:(___)_____

Autorizo a Erik Sloman-Moll MD PA a presentar una reclamacion a mi compania de seguro medico o de sus intermediarios para todos los servicios cubiertos o productos proporcionados por la pracitca. Yo entiendo que soy responsable de cualquier co-seguro, co-pago deducible, y cual quiera de los servicios no cubiertos. Yo entiendo que es la politica de la practica de recoger de estas al momento del servicio. Entiendo que es mi responsabilidad para confirmar el profesional es un proveedor de la red y actualizar mi archivo de seguro cada vez que cambio las companias de seguros. Yo entiendo que no proporcionar informacion actual me hara responsable inmediato de los saldos pagados de otra manera por mi compania medica. Yo entiendo que si me uno a una HMO, voy a informar a la practica antes de programar caulquier cita que el personal pueda identificar mi la elegibilidad para el cuidado con esta practica. Entiendo citas son pre-arreglado y que es mi responsabilidad de mantener mi cita o cancelar mi cita con una antelacion minma de 24 horas. Si no se cancela dara lugar a una tasa de cancelacion de $25. He completado la informacion por encima de un certificar que es verdadera y correcta a lo mejor de mi conocimiento. Voy a notificar a esta oficina de cualquier cambio en mi estado de salud de la informacion anterior.

Firma del Paciente o Guardian: _____ ***Fecha de Firma:***_____

ERIK ROBERT SLOMAN-MOLL MD PA
AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff to (check all that apply):

_____ use the following protected health information, and/or
_____ disclose the following protected health information to: _____
(Insert Name of Entity or Class of Persons to Receive Information)

_____

_____

_____

(Specifically and meaningfully describe the protected health information to be used or disclosed, such as date of service, type of service, level of detail to be released, origin of information, ect,)
The protected health information is being used or disclosed for the following purposes:

_____

_____

_____

(List specific purposes here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.)
This authorization shall be in force and effect until _____
(Specify (1) date or (2) event that relates to the patient or the purpose of the use or disclosure) at which time the authorization to use or disclose this protected health information expires. ***("End of the research study" and "none" is acceptable for authorization for research purposes.)***

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under the authorization will result in direct or indirect remuneration to my physician from a third party. ***(Applicable only if the authorization is obtained for marketing purposes.)***

_____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative Description of Personal Representative

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This is to acknowledge that I have received a copy of Erik R Sloman-Moll MD PA **Notice of Privacy Practices** this_____day of _____, 20____.

_____

Signature of Patient or Patient Representative

_____

Printed Name *If Representative, state relationship to patient*

Erik R. Sloman-Moll, MD
10410 Medical Loop Unit 4B
Laredo, TX 78045
Phone (956) 794-8870 Fax (956) 795-8384

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

To _____
(Physician or Hospital)

Address _____ Phone_____ Fax _____

I hereby authorize and request you to release confidential health information about me, by releasing a copy of my medical record or summary/narrative of my protected health information to the office of Erik R. Sloman-Moll, MD.

Patient Name _____ Date of Birth _____

HIV/AIDs: I consent to the release of any positive or negative testresults for AIDs/HIV infection, antibodies to AIDs or infection with any other causative agent of AIDs with the rest of my medical records.

_____ All Medical Records
_____ Radiology reports
_____ Recent Lab Work
_____ Allergy Results
_____ Progress Notes
_____ EKG
_____ Other

Release my protected health information to:
Erik R. Sloman-Moll, MD
10410 Medical Loop Unit 4B
Laredo, Tx

Signature_____ Date _____
(Parent or legal guardian)

Witness_____Date _____