



Camcare Medical  
 Paulette Stewart, M.D.  
 228-06 Linden Blvd. Cambria Heights, NY 11411  
 Tel.: 718-712-1219/ Fax: 718-712-1217

**REGISTRATION FORM**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** Male/Female

**Address** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_ **Home:** \_\_\_\_\_ **Work #** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Marital status:** Single Married Divorced Widowed Separated

**Are you employed?** \_\_\_ YES \_\_\_ NO. **If yes, Job title:** \_\_\_\_\_

**Race (circle one):** American Indian or Alaskan Native/ Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I decline To Answer.

**Ethnicity (circle one):** Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

**Do you have medical insurance?** \_\_\_ YES \_\_\_ NO **If yes,**

**Name of Primary Insurance:** \_\_\_\_\_ **Subscriber ID #** \_\_\_\_\_

**Do you have secondary coverage?** \_\_\_ YES \_\_\_ NO **If yes,**

**Name of Secondary Insurance:** \_\_\_\_\_ **Subscriber ID #** \_\_\_\_\_

**Who is responsible for this account?** SELF \_\_\_ OTHER \_\_\_\_\_

**Who should we contact in case of an emergency Contact Name:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_ **Emergency contact phone #:** \_\_\_\_\_

**Name of pharmacy:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**INSURANCE ASSIGMENT AND RELEASE**

**I certify that I, and/or my dependent, have insurance coverage with \_\_\_\_\_ and directly assign Dr. Paulette A. Stewart all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

**The above-named physician may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the payable for related services. This consent will end when my current treatment plan is completed or one year from date signed below.**

**PRINT name of patient, parent, guardian, or personal representative** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**GENERAL CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEDGMENT OF RECEIPT OF OUR PRIVACY PROCEDURES.**

Our accompanying Notice of Privacy Practices provides details of a new regulation intended to protect the privacy of patients. It describes how medical information about patients may be used and the kind of permission that patients must provide us in order to allow certain information to be used for various purposes.

The law requires us to provide you with this notice of privacy, and therefore, we need you to acknowledge that you have received it.

In addition, for us to continue to treat you, get paid for that treatment, and run our business, we need you to provide us with general written consent. This provides us with your permission to share your medical information with professionals involved in your care and with health insurance companies and other business associates of CamCare Medical.

Generally, in order for us to disclose your health information to others, we will ask you for a separate written authorization.

By signing below, I acknowledge that I have been provided with a copy of CamCare Medical's Notice of Privacy Practices. I have been advised of how health information about me may be used and disclosed and how I may obtain access to and control this information. I also acknowledge and understand that I may request a copy of separate notice that explains special privacy protections that apply to HIV, mental health, and substance abuse related information.

By signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care; to seek and receive payment for services rendered to me and for regular operations of CamCare Medical.

**I also give permission to leave a message at the telephone number (s) I have provided.**

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Signature of Patient or Personal Representative

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Date

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Print Name of Patient or Personal Representative

---- Self -----Parent/Guardian ----Other.