PATIENT REGISTRATION FORM

LAST NAME_____MIDDLE_____FIRST_____

SS#_____-___-_____BIRTHDATE_____MARITAL STATUS_____

RACE: ❒Indian ❒Asian ❒Black/ African American ❒ White ETHNICITY: ❒ Hispanic/Latino

❒Native Hawaiian/Other Pacific Islander ❒Other_____ ❒ Not Hispanic/Latino

PREFERRED METHOD OF NOTIFICATION: ❒ Home Phone ❒ Cell Phone ❒ Mail

PREFERRED LANGUAGE: ❒ English ❒ Spanish ❒ Other _____

PHONE_____CELL PHONE _____

ADDRESS_____CITY_____STATE_____

ZIP_____EMAIL ADDRESS _____

EMPLOYER_____WORK PHONE_____

SPOUSE/PARTNER'S NAME_____SS#_____DOB_____

CELL PHONE_____

SPOUSE/PARTNER'S EMPLOYER_____WORK PHONE_____

IN CASE OF EMERGENCY CONTACT_____RELATIONSHIP_____

ADDRESS_____PHONE_____

REFERRING DOCTOR_____ SURGEON_____

FAMILY DOCTOR_____

HOW DID YOU HEAR ABOUT GABRAIL CANCER CENTER? (Check all that apply) ❒Friend ❒Family

❒Doctor ❒Billboard ❒Internet/Website ❒Radio ❒Newspaper ❒Patient ❒Insurance ❒Other_____

SKILLED NURSING FACILITY (IF APPLICABLE)_____

PHARMACY NAME_____PHONE_____

ADDRESS _____

PRIMARY INSURANCE_____ SECONDARY INS_____

ID#_____ ID#_____

CARDHOLDER_____ CARDHOLDER_____

SS#_____DOB_____ SS#_____DOB_____

HOSPITAL PREFERRED: AULTMAN_____MERCY_____UNION_____OTHER_____

ALLERGIES_____

ASSIGNMENT AND RELEASE: I hereby authorize that my insurance benefits be paid directly to the physician. I authorize the physician to release any information required to process any claims to authorized agents from my insurance company. I understand that I (as well as my spouse, if applicable) am financially responsible for any non-covered services provided to me.

PATIENT SIGNATURE_____DATE_____

WITNESS SIGNATURE_____DATE_____

MEDICAL INFORMATION

Date:_____

Please list your medications below please include date started and how many times per day taken.

Medications	Start Date	Dose	Frequency	D/C Date

Past Medical History

Past Surgical History

GABRAIL CANCER CENTER

4875 Higbee Ave NW - Canton, Ohio 44718
Phone (330) 492-3345
Fax (330) 491-9758

MEDICAL RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM/TO:

DR._____

ADDRESS_____

CITY_____STATE_____ZIP_____

_____ _____
PATIENT NAME PATIENT SIGNATURE

_____ _____
DATE OF BIRTH SOC SEC #

_____ _____
ADDRESS CITY/STATE/ZIP

_____ _____
DATE WITNESS OR REPRESENTATIVE

*This authorization shall expire 1 year from today's date except as indicated below.
*I may revoke the authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on any previous requests before the revocation date.
*NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

NASHAT Y. GABRAIL, M.D., INC.
dba GABRAIL CANCER CENTER

4875 Higbee Ave. NW, Canton, Ohio 44718
PH (330) 492-3345 FX (330) 491-9758

Individual Authorization

Patient Name:_____ID Number:_____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

A representative of NASHAT Y. GABRAIL, M.D., INC., must answer these questions completely before providing this authorization form to you. DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? The person(s) or class of persons authorized to disclose the information are described below.

The physician(s) and other clinicians and staff members within Nashat Y. Gabrail, M.D., Inc.

Who will use and/or receive the information? The person(s) or class of persons authorized to use and/or receive the information are described below.

The physician(s) and other clinicians and staff members within Nashat Y. Gabrail, M.D., Inc.

What information will be used or disclosed? The description below should be in enough detail so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used or disclosed.

Consultation/progress notes and/or clinical results/findings related to your total health and well-being.

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below.

To provide or facilitate treatment for your health and well-being.

When will this authorization expire? The date or event that will trigger the expiration of this authorization should be described below.

Authorization will terminate upon notification, in writing, from you or your personal representative.

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health

information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. However, if your refuse to sign this form, then you or your personal representative will be asked to sign a medical release form each time records need to be released, except for treatment, payment, and normal business operations, disclosures to friends/family involved in your care, emergency or public need, or if information does not identify you.

You have a right to see and copy the information described on this authorization form in accordance with our record access policies. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that we have already taken action based upon your authorization. To revoke this authorization, please write to Shelly Rentsch, Practice Administrator, 4875 Higbee Ave NW, Canton, OH 44718.

CONTACT INFORMATION

I authorize the following person(s) to have access or knowledge of my medical well-being

Print Name	**Relationship**	**Phone Number**
Print Name	**Relationship**	**Phone Number**
Print Name	**Relationship**	**Phone Number**
Print Name	**Relationship**	**Phone Number**
Print Name	**Relationship**	**Phone Number**

I have read this form and all my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all the above.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE SHOULD BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

NASHAT Y. GABRAIL, M.D., INC. dba GABRAIL CANCER CENTER
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PH (330) 492-3345 FX (330) 491-9758

Advanced Directives Information

I acknowledge that I have the following Advanced Medical Directives in place and have provided the office with a signed copy. Please mark all that apply:

☐ Living Will
☐ Power of Attorney
☐ DNR
☐ None of the above

_____ _____
Signature of Patient Date

_____
Witness or Personal Representative

Verification of Benefits

If you would like to have your information reviewed to see if you qualify for any assistance with co-pays or costs related to any possible treatment discussed, please provide the following information so it can be forwarded to our patient assistance department:

Household size: _____

Total household income: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____ ID Number:_____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of NASHAT Y. GABRAIL, M.D., INC.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Representative's Authority

The contact information of the person signing this form (if other than the patient):

Address: Telephone:

_____ _____ home

_____ _____ cell