# *WILLIAM H. GENTRY, MD, FACS*

## Patient Registration Information

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Last Name _____ First Name _____Middle Name _____

Nickname? _____ Male _____ Female _____ Date of Birth _____ - _____- _____

Mailing Address _____Apt#_____ City _____ State _____ Zip _____

Home Phone # (_____)_____ Cell Phone # (_____)_____

E-Mail address _____@_____Social Security # _____

Marital Status _____ Spouse Name _____ Spouse Cell# _____

Pharmacy You use? _____ City: _____

NEW GOVERNMENT REGULATIONS REQUIRE US TO ASK THE FOLLOWING QUESTIONS

Race _____ [ ] *Decline to State* Are you Hispanic? Yes_____No_____ [ ] *Decline to State*

Do you speak English? _____ Preferred language _____

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Current Occupation _____ Previous work if Retired_____

Employer _____ Work Phone (____)_____

Spouses Occupation _____ Work Phone ( )_____

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Referring Physician _____

Other Physicians who care for you _____

Emergency Contact : _____ Relationship _____

Address _____ Home Ph (___)_____ Work/Cell (___)_____

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***Please allow us to photocopy your insurance cards & Driver's License*

**Primary Insurance** _____ID Number _____ Group # _____

**Second Insurance** _____ID Number _____ Group # _____

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**Assignment of Benefits-Financial Agreement**: *I hereby give lifetime authorization for payment of insurance benefits to be made directly to* WILLIAM H. GENTRY, MD*, for services rendered. I understand that I am ultimately financially responsible for* all *charges, whether or not they are covered by insurance. A service charge of 1 1/2% per month (18% per annum), but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within* 30 days *of treatment date. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I here by authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.*

**Your Signature** _____ **Date** _____

# Acknowledgement of receipt of notice of privacy practices

William H. Gentry, MD FACS
430 Rio Street Red Bluff, CA 96080
530-528-0801
If you have questions, please notify our Privacy Contact, Jill at the number above

A Notice of Privacy Practices for our office is available at your appointment. By signing below you acknowledge that a copy of the current notice is available in the reception area, and that copies are offered and given upon request.

Signed _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, indicate Relationship: _____

**With your permission, we can provide you access to your medical information by sending a link through your email, please indicate below:**

**{ } YES, provide me the link information** **{ } NO, I decline this information**

Authorized Methods of Communication (please check all the apply)

| Residence Telephone | Work Telephone | Written Correspondence |
|---|---|---|
| { } Leave call back number only. Do not leave message | { } Leave call back number only. Do not leave message | { } Mail/Delivery service |
| { } Okay to leave detailed message with person | { } Okay to leave detailed message with person | { } Fax: ( ) |
| { } Okay to leave detailed message on answering machine | { } Okay to leave detailed message on answering machine | { } Other (please specify) |

List names of family or friends with whom we may share your health information with

| Name | Relationship |
|---|---|
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