AZ Medical Services

Zergabachew Asfaw, M.D., FACP, CMD
2426 Eastchester Rd, Suite 101, Bronx, NY 10469 Phone (718) 708-4726 Fax (347) 336-6232

New Patient Registration

Please print clearly or type

PATIENT INFORMATION

Last name | First name | Middle initial

Date of birth (MM/DD/YYYY) | Preferred name | Pronouns (optional)

Sex assigned at birth: ☐ Female ☐ Male ☐ Prefer not to say

Gender identity (optional): ☐ Woman ☐ Man ☐ Non-binary ☐ Another identity ☐ Prefer not to say

Marital status: ☐ Single ☐ Married / partner ☐ Divorced ☐ Widowed ☐ Separated

Street address | Apt / unit

City | State | ZIP code

Mobile phone | Home phone | Work phone

Email | Preferred language

Do you need an interpreter? ☐ No ☐ Yes

Best way to reach you: ☐ Mobile phone ☐ Home phone ☐ Text message ☐ Email ☐ Mail

May we leave a detailed message about appointments or results? ☐ Voicemail ☐ Text message ☐ With a family member ☐ No, only ask me to call back

Special needs for visits: ☐ Wheelchair or walker ☐ Hearing help ☐ Vision help ☐ Someone comes with me ☐ None

EMERGENCY CONTACT

Full name | Relationship to patient

Phone | Other phone

CAREGIVER OR FAMILY MEMBERS WE MAY SPEAK WITH ABOUT YOUR CARE (OPTIONAL)

List anyone you would like us to be able to talk with about your health, appointments and care. You can change this at any time by telling us.

Full name	Relationship	Phone

HEALTH CARE PROXY (NEW YORK)

Do you have a health care proxy? ☐ No ☐ Yes (please bring a copy)

Health care agent's name | Phone

Confidential patient information. Please bring this form to your visit or fax it to (347) 336-6232. Please do not email it.

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New Patient Registration

continued

PRIMARY INSURANCE

☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Commercial / employer ☐ Self-pay

Insurance company / plan name | Member ID | Group number

Policyholder name | Policyholder date of birth | Relationship to patient

SECONDARY INSURANCE (IF ANY)

☐ Medicare supplement (Medigap) ☐ Medicaid ☐ Commercial / employer ☐ Other

Insurance company / plan name | Member ID | Group number

Policyholder name | Policyholder date of birth | Relationship to patient

Please bring your insurance cards and a photo ID to every visit.

PERSON RESPONSIBLE FOR THE BILL (IF NOT THE PATIENT)

Full name | Relationship to patient

Address | Phone

YOUR CARE TEAM

Previous primary care doctor | Phone

Who referred you to us? | Phone

Preferred pharmacy name | Pharmacy phone

Pharmacy address / cross streets

OPTIONAL INFORMATION

Federal rules ask doctors to collect this to help make sure everyone gets fair, high-quality care. Answering is your choice and will not affect your care.

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Prefer not to say

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to say

How did you hear about us? ☐ Family or friend ☐ Another doctor ☐ Insurance ☐ Internet search ☐ Website ☐ Other

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CONSENT AND ACKNOWLEDGMENTS

Please read each statement and initial it.

Initials _____ **Consent to treatment.** I agree to examination and treatment by the doctors and staff of AZ Medical Services. I understand I may ask questions and refuse any test or treatment.

Initials _____ **Insurance and payment.** I authorize payment of insurance benefits directly to AZ Medical Services and allow the practice to share the information my insurer needs to process claims. I understand I am responsible for co-pays, deductibles and any charges my insurance does not cover.

Initials _____ **Notice of Privacy Practices.** I have received, or been offered, a copy of the practice's Notice of Privacy Practices, which explains how my health information may be used and shared.

Initials _____ **Prescription history.** I allow the practice to view my medication history from my pharmacy and insurer, so the doctor can prescribe safely.

Signature of patient or legal representative _____ Date _____

Printed name _____ If signed by a representative: relationship / legal authority _____