Cindy Alberts Carson, MD
625 S. Fair Oaks Ave. • Suite 245
Pasadena, CA 91105
(626) 793-9353

Patient Registration

NOTE: If these forms opened automatically in your browser window, please do a "Save As" from the File menu, then open that file using Acrobat Reader. You can then save the information you enter. Information entered by way of the browser can be printed, but not saved. These forms can be completed on your computer, by simply clicking in the shaded area next to each item and typing in the designated space. All items named in blue are required; other items are optional. Please print and bring the completed forms with you to your first visit, and as a backup e-mail the completed forms to registration@cindycarsonmd.com.

General Information

Name _____

Address _____

City _____ **State** _____ **ZIP** _____

Home Phone (_____) _____

Work Phone (_____) _____

Cell Phone (_____) _____

E-mail _____

Emergency Contact (name) _____

Emergency Contact (phone) (_____) _____

Date of Birth _____

Social Security Number _____

Occupation _____

Employer _____

Referred By _____

Insurance/Financial Information

Insurance Carrier

Subscriber Name

*(This is the name of the person listed as the subscriber with the insurance company; it **might or might not be your name)***

Your relationship to the subscriber Self

Insurance ID Number

(This is your unique ID number; it can be called by different names, such as "Member ID" or "User ID")

Group Number

(This is usually called "Group number" "Group ID" or something similar)

Responsible Party (if other than you, the patient)

Name

Address

City **State** **ZIP**

Phone ( )

Other

Your health information is confidential. We will not allow anyone to have access to results, pick up prescriptions for you, or receive information about your health unless you list them here:

_____

Do you agree to be financially responsible for the services performed by this practice if, for any reason, you are not eligible for health insurance benefits from your provider?

◉ **Yes** ○ **No**

_____ **Date**

Patient or Responsible Party Signature

Please bring your insurance card to every visit

Your Name

Prescription Medications

Name	Dose	Frequency

Please list additional medications on the reverse

Vitamins, Supplements, Herbal and Over the Counter Medicines

Please list additional items on the reverse

Known allergies to medications (if none, please state "none"):

Have you ever experienced an allergic reaction to shellfish, iodine or injected dyes used in some x-ray, CT, and MRI procedures?

○ **Yes** ○ **No**

Health History

I will be asking you about your past medical problems, surgeries, and hospitalizations, as well as recent testing such as colonoscopies, blood work, etc.

I will also be asking you about your family's medical history. Please use this page and the reverse to make any notes to yourself that would be helpful for this conversation, including dates of major illnesses and procedures, and health information about your parents, siblings, and other relatives.

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Authorization to Transfer Medical Records

I _____ hereby authorize

_____, MD to furnish the

following medical information about the undersigned to Dr. Cindy Carson. Any and all information may be released, including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and alcohol abuse records, and HIV test results, if any.

1. Any laboratory results from the previous 12 months.
2. Any imaging results from the previous 5 years.
3. Records of any screening or diagnostic tests (e.g. colonoscopy, DEXA, mammograms, Pap smears, biopsies, EKGs)
4. Records of any consultations from the previous 5 years.
5. A recent progress note, if available.

I understand that I may be charged a reasonable fee for photocopying and/or transmittal of these records.

This request authorization is effective for 30 days from the date it is signed.

_____ Date _____

Patient

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Contact Permissions

Please tell me how you prefer to be contacted by checking the boxes below where you AGREE to have me call, e-mail, leave a message, or send a report.

If you are filling out this form electronically, just click to check any box.

	OK To Use	Don't Use	Speak to Me Only	Speak To Me Or Partner	OK To Leave Msg.
Home phone	☐	☐	☐	☐	☐
Work phone	☐	☐	☐	☐	☐
Cell Phone	☐	☐	☐	☐	☐
E-mail (appt. info)	☐	☐			
E-mail (lab results)	☐	☐			
E-mail (other)	☐	☐			

I understand that I may change these choices at any time by notifying Dr. Carson.

_____ _____

Signature Date