ADULT REGISTRATION FORM: Please complete the entire registration form.
PLEASE EMAIL THIS FORM BACK TO GSUSCREG@GSUNJ.COM OR FAX TO 973-627-1095

PATIENT'S LAST NAME	
PATIENT'S FIRST NAME	
PATIENT'S DATE OF BIRTH	
PATIENT'S SEX	
PATIENT'S ADDRESS	
APT., SUITE OR FLOOR	
CITY, STATE & ZIP CODE	
PATIENT'S PHONE #	
EMAIL ADDRESS	
RELIGION	
MARITAL STATUS	
RACE	
PRIMARY LANGUAGE	
PRIMARY CARE DOCTOR & PHONE NUMBER	
REFERRING PROVIDER & PHONE NUMBER	
PHARMACY NAME , TOWN, PHONE NUMBER	
ORGAN DONOR?	**YES OR NO**
ADVANCE DIRECTIVE/LIVING WILL	**YES OR NO**
POWER OF ATTORNEY/DPA	**YES OR NO**
EMERGENCY CONTACT NAME	
RELATION TO PATIENT	
EMERGENCY CONTACT PHONE #	
PATIENT'S EMPLOYER/OCCUPATION	
EMPLOYMENT STATUS	PLEASE SELECT FULL-TIME
GUARANTOR NAME	
RELATION TO PATIENT	
GUARANTOR'S DATE OF BIRTH	
GUARANTOR'S ADDRESS	

CITY, STATE, ZIP CODE	PLEASE EMAIL THIS FORM BACK TO GSUSCREG@GSUNJ.COM OR FAX TO 973-627-1095
GUARANTOR'S SOCIAL SECURITY NUMBER	
GUARANTOR'S EMPLOYER	
GUARANTOR'S EMPLOYER ADDRESS	
GUARANTOR'S OCCUPATION	
GURANTOR'S EMPLOYER PHONE #	
PRIMARY INSURANCE	
INSURANCE NAME, ADDRESS, AND PHONE NUMBER	
POLICY NUMBER	
GROUP NUMBER	
SUBSCRIBER NAME	
RELATION TO PATIENT	
SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S ADDRESS	
CITY, STATE, ZIP CODE	
SUBSCRIBER'S PHONE #	
SUBSCRIBER'S EMPLOYER	
SUBSCRIBER'S ADDRESS	
SUBSCRIBER'S EMPLOYMENT STATUS	PLEASE SELECT
SUBSCRIBER'S EMPLOYER PHONE #	
SECONDARY INSURANCE	
INSURANCE NAME, ADDRESS, AND PHONE NUMBER	
POLICY NUMBER	
GROUP NUMBER	
SUBSCRIBER NAME	
RELATION TO PATIENT	
SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S ADDRESS	
CITY, STATE, ZIP CODE	

SUBSCRIBER'S PHONE #	PLEASE EMAIL THIS FORM BACK TO GSUSCREG@GSUNJ.COM OR FAX TO 973-627-1095
SUBSCRIBER'S EMPLOYER	
SUBSCRIBER'S ADDRESS	
SUBSCRIBER'S EMPLOYMENT STATUS	
SUBSCRIBER'S EMPLOYER PHONE #	
SUBSCRIBER'S OCCUPATION	

PLEASE EMAIL THIS FORM BACK TO GSUSCREG@GSUNJ.COM OR FAX TO 973-627-1095

EDUCATION MATERIALS:

All patients will receive the following:

- Patient's Rights and Patient's Responsibilities
- Notice of Privacy Practices
- Patient Guide

Inpatients - Please review for education on the following:

- Your Right to Make Decisions About Your Medical Treatment
- An Important Message from Medicare (Medicare/HMO Medicare Only)
- Understanding Your Pain
- Patient Safety
- Smoking Cessation Information
- Pneumococcal Vaccine Information (Publication date 04/25/2015)
- Influenza Vaccine Information (During the Current Flu Season) (Publication date 08/07/2015)

HEALTHCARE DIRECTIVE

Do you have a Healthcare Directive or a Living Will? ..... ☐ YES ☐ NO

Have you provided us with a copy? ☐ Yes ☐ No

1. If no, then note healthcare wishes below: _____

_____

I permit _____ to be involved in the care, treatment and service decisions during this hospital stay.

By signing below, I acknowledge that I have been provided the required **Educational Materials** and **Healthcare Directive** information.

_____ _____

Signature of Patient / Patient's Representative Date/ Time

_____ _____

If other than patient, include relationship. Witness

FOR STAFF USE ONLY:

If you are unable to provide any of the above information to the patient because of an emergency treatment situation, describe below the good faith efforts that you made to provide such information to the patient:

_____

_____

_____ _____

Employee Signature Date/ Time

NJ Saint Clare's | Patient ID

CONDITIONS OF ADMISSION

PLEASE EMAIL THIS FORM BACK TO GSUSCREG@GSUNJ.COM OR FAX TO 973-627-1095

SAINT CLARE'S HEALTH SYSTEM

HEALTH DATA EXCHANGE

PATIENT NAME:_____ **ACCOUNT NUMBER:**_____

Jersey Health Connect Health Information Organization (HIO)

Saint Clare's Health System has partnered with the Jersey Health Connect HIO to take part in the New Jersey Health Information Exchange (HIE) pursuant to federal requirements. The purpose of an HIE is to allow physicians and healthcare providers and facilities from across the state to share their patients' health information electronically for improving the quality of health care services provided. The goals for using an HIE are to have timely information about the patient's medical condition, reduce medical and medication errors, and reduce or eliminate duplicate tests and unnecessary costs. Patients can access the HIE to obtain their health information and become a more active, informed participant in their overall health care. New Jersey laws and federal regulations have strict privacy and security requirements that HIE participants must comply with in order to protect patient privacy and confidentiality.

Patient information contained and shared in the HIE may include office, hospital, and other health care treatment and services including sensitive information such as the diagnosis or suspected diagnosis of HIV/AIDS, sexually transmitted diseases, mental health and drug and alcohol treatment, genetic testing, genetic information, services paid for out-of-pocket in full, care or services received as an emancipated minor under state law, and any other health information for which the law requires prior written consent. *Information relating to mental health facility admissions and visits and all health information for patients aged 12 to 17 years will not be shared through the HIE.*

The patient's health information will automatically be available to the HIE participants. However the patient may choose to opt out of the HIE at anytime by contacting Jersey Health Connect directly by toll-free number (855) 624-6542 or via the Internet at http://www.jerseyhealthconnect.org If the patient chooses to opt out of the HIE, their health information will only be available for access by those physicians and entities directly affiliated with Saint Clare's Health System.

Information Exchange Acknowledgment

By signing below I acknowledge that I understand Saint Clare's Health System will share my health information, through the Jersey Health Connect HIE, with all individuals and entities that are authorized to access such information for purposes related to my treatment and care. I understand this includes the protected health information described above. I also acknowledge that I am entitled to opt-out of this electronic health exchange by contacting Jersey Health Connect directly. I understand that I may choose to opt-out at a later date by contacting Jersey Health Connect however information may have been previously submitted and viewed by my healthcare providers prior to the opt-out date.

_____ _____

Patient or Legal Representative Signature | Printed Name & Authority of Legal Representative (If Applicable)

Pharmacy Health Information Exchange (E-Prescribe) Consent

Saint Clare's Health System has the ability to obtain a patient's prescription medication history information electronically through a pharmacy health information exchange. Healthcare providers such as physicians, pharmacies, and insurance companies participate in this exchange in order to improve the administration of care and facilitate the billing process.

I do ☐ do not ☐ consent to having my drug benefit coverage and medication history electronically accessed and retrieved from the national electronic prescribing network.

_____ _____

Patient or Legal Representative Signature | Printed Name & Authority of Legal Representative (If Applicable)

_____ _____ _____

Witness Signature | Date | Time

Using the patient's primary language (if other than English), _____ the interpreter acknowledges the patient understands and agrees with the above statements.

_____ _____

Interpreter Signature | Interpreter Printed Name