MOUNT SINAI ROBERT PROSTATE CANCER SCREENING UNIT PATIENT REGISTRATION FORM

DATE: _____/_____/_____

NAME: _____

DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP:_____

EMAIL:_____@_____

HOME#_____WORK#_____

CELL#_____

Emergency Contact (Name, Number, Relationship) _____

Why are we asking about your race, ethnicity, language and pronouns?

We want to make sure that every patient receives personalized health care and is able to live their healthiest life. We ask all of our patients about their race and ethnicity so that we can address any differences in health outcomes across the communities we serve. We also ask everyone about language and pronouns so that we are providing care in a respectful way. Everyone's responses are private.

DO YOU IDENTIFY WITH SPANISH/HISPANIC/LATINO ETHNICITY? (select or write in up to two)

- ○ I am Spanish/Hispanic/Latino
- ○ I am not Spanish/Hispanic/Latino
- ○ I decline to respond
- ○ If you identify as Spanish/Hispanic/Latino, please let us know your specific background. For example: Dominican, Latin American, Mexican, Puerto Rican

_____

PLEASE TELL US WITH WHICH RACE(S) YOU IDENTIFY: (select or write in up to two)

"Race" is one way our society groups people together. Categories of race have been made up over time. These categories are often based on things we can see, like a person's skin color. Our race is a combination of the races of our parents.

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African-American
- ○ Native Hawaiian or Pacific Islander
- ○ Other
- ○ White
- ○ I decline to respond
- ○ Please let us know your specific background. For example: Asian-Indian, Bangladeshi, Chinese, Filipino, Haitian, Pakistani

_____

WHAT ARE YOUR PRONOUNS AND PREFERRED LANGUAGE?

"Pronouns" are how we want to be referred to in addition to our name.
Common pronouns include "He/Him," "She/Her" and "They/Them."

Pronouns (optional – choose one):

○ He/Him ○ She/Her ○ They/Them

"Language" is what we speak, read, and write. Some people may know more than one language, but are more comfortable with one language versus another.

- ○ Language:

_____

MOUNT SINAI ROBERT PROSTATE CANCER SCREENING UNIT PATIENT REGISTRATION FORM

PATIENT NAME: _____DOB:_____

PATIENT MEDICAL INFORMATION RELEASE

I hereby allow the release of my health information, studies imaging reports and any other pertinent health material to Dr. Ashutosh Tewari and Mount Sinai Hospital as requested by their administrative office. Please release materials they request for my upcoming treatments, procedures or Robotic Prostatectomy as soon as possible.

Patient Signature X _____Date:_____

EMAIL CONSENT & AREEMENT TO RECEIVE MESSAGES CONTAINING PHI

(Patient Health Information) AT HOME

EMAIL

I, consent to have my physician, communicate with me or members of their staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding aspects of my medical care and treatment (test results, prescriptions, appointments, billing, etc.). I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners, and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of their office staff or between my physician and other physicians, nurse practitioners, or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

AGREEMENT TO RECEIVE MESSAGES

I hereby authorize Dr. Ashutosh Tewari and Mount Sinai Hospital as requested by their administrative office to leave a message containing PHI necessary for my care.

Patient Signature X _____Date:_____

EMAIL: _____

PHONE: _____