



# Patient Registration Form

Is today's visit work related? If yes Do not complete this form. Please see the front desk staff for instructions.

Was this the result of a motor vehicle accident? Yes No How did you hear about us? \_\_\_\_\_

What's the reason for your visit today? \_\_\_\_\_

## PATIENT INFORMATION \*For more information on the confidential phone and email, please see the attached consent form

Name Male Female

Primary Care Physician

SS# DOB

PCP Address

Street Address Apt#

PCP Phone

City, State, Zip

Preferred Pharmacy

Home Phone Cell Phone

Pharmacy Phone

\*Confidential Phone

Best Form of Contact Cell Home Email Mail

Home Email

Best Time to Call May we leave a message? Yes No

\*Confidential Email

Based on government regulations, we are required to ask the following:

In order for us to service your account or to collect any amounts owed to us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which may result in additional charges from your phone carrier. We may also contact you by sending text messages or emails, using all e-mail addresses that you have provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

- Hispanic or Latino Non-Hispanic or Non-Latino
American Indian or Alaska Native Asian
Black or African American Caucasian
Native Hawaiian I prefer not to answer

By initialing, I acknowledge that I have read this disclosure and agree that you may contact me as described above.

## EMERGENCY CONTACT

Name

Relationship

Street Address Apt#

Home Phone

City, State, Zip

Cell Phone

## FINANCIAL RESPONSIBILITY Check if same as patient information. If not, please complete the entire section

Name Male Female

Relationship

SS # DOB

Phone

I acknowledge full financial responsibility to any services received and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign endurance benefits to this office. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees and/or Attorney's fees and all court costs, if any.

Signature

Date

## INSURANCE INFORMATION Check if same as patient information. If not, please complete the entire section

Primary Insurance

Secondary Insurance

Plan

Plan

Subscriber Name

Subscriber Name

DOB Relationship

DOB Relationship

## CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Parent/Guardian Signature (If patient is a minor)

Date

## NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature

Date