

Patient Registration Form

Date:

PATIENT INFORMATION

First name		Last name		Initial	Birthdate	Age
Sex: (mark an option) ☐ Female ☐ Male	Social Security #	Phone number	Alternative phone number		E-mail	
Address		Apartment number	City		State	PO
Race: (mark an option) American Indian or Alaska Native Black or African American Native Hawaiian or Other Pacific Islander White Hispanic Asian Other:						
Etnicidad: (mark an option) ☐ Hispano ☐ Otro	Preferred language		Pharmacy and Preferred Location		Phone number	
Emergency Contact		Relationship		Phone number		

How did you hear about us?

Family/Friendship Insurance Website Location Community Event Other: _____

COMPLETE THIS SECTION IF THE PATIENT IS A MINOR (under 18 years of age)

Name of representative		Last name		Relationship	Initial	Birthdate	Age
Sex: (mark an option) ☐ Female ☐ Male		Social Security #		Phone number	Alternative phone number	Driver license	

INSURANCE AND SUBSCRIBER INFORMATION

PLEASE PROVIDE ALL INSURANCE CARDS TO THE RECEPTION

Primary Insurance		Member ID		Group Number		Employer
Name of the Policyholder			Birthdate		Relationship	

PATIENT PORTAL

To ensure better service, we provide online services that allow patients to conveniently make appointment requests, view lab results, check their vital signs, and obtain other useful patient information. We highly recommend this as this service is free of charge. Please indicate below if you would like to receive information through our Patient Portal:

- ☐ Yes, I wish to communicate using the secure Patient Portal system, which is designed to keep my information safe. I understand that I will be notified by email when secure information is available for review.
- ☐ No, I do not wish to participate in the Patient Portal

Signature	Email
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CONSENT FOR TREATMENT

I hereby authorize the employees and agents of XXX (including physicians, physician assistants, nurse practitioners, and other staff members) to perform medical evaluations and care for the patient listed below. I understand that a registered nurse (XXXXX) qualified to practice medicine is not a physician. I also understand that a registered nurse is a graduate of a certified training program and is licensed by the State Board. Under the supervision of a physician, a registered nurse/nurse practitioner may diagnose, treat, and monitor acute and chronic illnesses, as well as provide health maintenance care. Supervision does not require the physical presence of a supervising physician. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not receive medical care except in an emergency.

Signature of Patient, Parent or Legal Guardian _____ Printed Name of Legal Guardian (if patient is a minor) _____

I, the undersigned, consent and grant permission to XXXXXXXX, LLC, XXXXXXXXXX, XXX, XXXXX and its employees to perform testing, treatment and any procedures for the above or my named minor.

AUTHORIZATION

I request that payment of authorized Medicare benefits be made, either in my name or on my behalf, to XXXXXXXXXXXXXXXXXXXX, LLC, XXXXXXXXXXXXXXXX, XXX, XXXXX for any services rendered to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any signature request for payment and authorize the release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of Form XXXXXXXX, or elsewhere on other approval claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown in the cases assigned by XXXXXXXX, the provider agrees to accept the coverage determination for XXXXXXXX's insured to pay the bill, and the patient is responsible only for the deductible, coinsurance, and non-covered services. The coinsurance and deductible are based on XXXXXXXX's insured's charge determination.

Signature of Patient, Parent or Legal Guardian _____ Date: _____