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

SS# DOB

Street Address Apt#

City, State, Zip

Home Phone Cell Phone

*Confidential Phone

Home Email

*Confidential Email

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.

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

Primary Care Physician

PCP Address

PCP Phone

Preferred Pharmacy

Pharmacy Phone

Best Form of Contact ☐ Cell ☐ Home ☐ Email ☐ Mail

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

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

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

EMERGENCY CONTACT

Name

Street Address Apt#

City, State, Zip

Relationship

Home Phone

Cell Phone

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

Name ☐ Male ☐ Female

SS # DOB

Relationship

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

Plan

Subscriber Name

DOB Relationship

Secondary Insurance

Plan

Subscriber Name

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

This AFC location is locally owned and operated by: _____ Updated: 01/2018