Patient Registration Form

Divinity Medical Services, PLLC ("DMS")

REASON FOR VISIT: _____

PATIENT INFORMATION

Date of Birth: SS #:

First Name:

Last Name:

Street Address: Apt:

City: State: Zip:

Home Phone #:

Cell Phone #:

Email:

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

Sex at Birth: ☐ Male ☐ Female ☐ Unknown

Sexual Orientation:

Gender Identification:

Preferred Pronoun: He / She / They / Other:

Primary Care Physician (PCP):

PCP Address:

PCP Phone #:

Preferred Pharmacy:

Pharmacy Phone #:

EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Home Phone #:

Cell Phone #:

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

What is your preferred language:

Race:

- ☐ American Indian or Alaska Native
- ☐ Black or African American Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Caucasian
- ☐ I prefer not to answer

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ I prefer not to answer

INSURANCE INFORMATION

Primary Ins: Ins #:

Name of Insured:

Date of Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Ins: Ins #:

Name of Insured:

Date of Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

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

Name: ☐ Male ☐ Female

Date of Birth: SS #:

Relationship:

Phone #:

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

Signature: **Date:**

I authorize DMS, its affiliated AFC Urgent Care franchise offices, and all billing services, collection agencies, attorneys, or other agents who may work on their behalf, to contact me via voicemail, email, and text at the telephone numbers and email address provided above. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I understand that voicemail, email, and text messaging are not secure formats of communication. There is some risk that individually identifiable health information or other confidential information contained in such voicemail, email, and text may be misdirected, disclosed to, or intercepted by unauthorized third parties. I may revoke or withhold my consent to use any one or more of these means of communication at any time for my health information but will maintain at least one method for DMS to contact me for billing and insurance issues.

Signature: **Date:**

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

Signature: **Date:**

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:**