PATIENT REGISTRATION FORM **DATE** _____

LEGAL NAME: _____ NICKNAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ DOB: _____/_____/_____ Age: _____

PHONE: (primary) _____ (secondary) _____

EMPLOYER: _____ POSITION _____

MARITAL STATUS: S M D W SOCIAL SECURITY # _____/_____/_____ SEX: M F

EMAIL: _____

EMERGENCY CONTACT: _____

PHONE: (primary) _____ (secondary) _____

RELATIONSHIP TO PATIENT: _____

MINORS: FINANCIALLY RESPONSABLE PERSON: _____

DOB: _____/_____/_____ SOCIAL SECURITY # _____/_____/_____

PHONE: (H) _____ (W) _____ (C) _____

PLEASE CHECK IF THIS VISIT IS RELATED TO ONE OF THE FOLLOWING:

_____WORKERS COMP. _____ AUTO INSURANCE _____ LIABILITY CLAIM _____ OTHER: _____

Mandatory Consent

*I have been provided with a copy of the **Patient Payment Policy**, which details the financial terms associated with my services. I have read and understand the policy and agree to the terms.*

✓ **Signature:** _____ **Date:** _____

*I have been provided with a copy of the **HIPPA Privacy Policy**, which details my medical privacy rights. I have read and understand the policy and agree to the terms.*

✓ **Signature:** _____ **Date:** _____

Voluntary Consent

Common verbal and written transmittals such as appointment times, surgery information, test results, billing inquiries, prescription refills, or questions on any medical information pertaining to the patient is deemed protected health information and cannot be released to anyone other than the patient without the patient's informed consent. By signing below and naming an individual(s) you are authorizing us to share this information with the person. We will not speak with anyone other than the patient if no person is listed below.

✓ **Signature:** _____ **Date:** _____

Authorized Individual(s): _____