

Patient Registration Information

Today's Date:	Primary Dr:	Referring Dr:
First Name:	Last Name:	Middle Initial: Sex:
DOB:	Age:	SS#:
Address:		
Zip Code:	Home #:	Mobile #:
Marital Status:	Race:	Ethnicity:

If patient is not the Guarantor, please complete:

Name:	DOB:
Relationship to Patient:	SS#:
Address:	
Home #:	Mobile #:

Confidentiality and Emergency Contact:

Due to the importance of protecting the confidentiality of the patient's medical information, we will not verbally disclose any medical information to the patient's family, friends, significant others or any other individual unless the patient has authorized the release of medical information by specifying in writing the list of people who may obtain such medical or private information. (A signed release will still be needed for printed records).

Name:	Relationship:	Phone #:	Emergency Contact:	Leave Message and Speak with:	Review Your Account:	Pick up Prescription, Orders and Medical Records:
			Yes__ No__	Yes__ No__	Yes__ No__	Yes__ No__
			Yes__ No__	Yes__ No__	Yes__ No__	Yes__ No__
			Yes__ No__	Yes__ No__	Yes__ No__	Yes__ No__

Patient Portal:

I consent to participate in the PATIENT PORTAL and understand that my personal health and individually identifying information is made available to me and/or my designee in the web-based portal application. I understand that I am responsible for safeguarding my access information and should I choose to provide access to an authorized representative, they would have the same ability to perform all the same functions I am able to perform. **YES** ___ **NO** ___

Email:

Pharmacy/Laboratory/Imaging:

What is your preferred pharmacy? (Name and Location):		
Do you consent to have your medications retrieved electronically from the pharmacy?	Yes ___	No ___
Preferred Lab:	Preferred Imaging:	

Signature:

I hereby confirm that the above information is accurate and true:

Patient/Guardian Signature:	Relationship:
Printed Name:	Date: