



# Patient Registration Form

ALD12212011

Symptoms/Reason for today's visit? \_\_\_\_\_

## PATIENT INFORMATION

Last name: \_\_\_\_\_ First \_\_\_\_\_ MI: \_\_\_\_\_ Gender  M  F

DOB \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status (circle one): S M D W

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(if patient is under the age of 18)

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_ Phone: Home ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Cell ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Work ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**Race (circle one):** Asian Native Hawaiian/Pacific Islander Black/African American  
American Indian Alaskan Native White  
Other: \_\_\_\_\_

**Ethnicity (circle one):** Hispanic/Latino Non- Hispanic/Latino

**Language (circle one):** English Spanish German Other \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**Employer:** \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_ **Location/Phone Number:** \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance**

Plan Name \_\_\_\_\_

Policy/Subscriber ID# \_\_\_\_\_

Group Number \_\_\_\_\_

Insured's Information  
 Check here if patient is primary member on plan.  
 (Only complete below if Primary on insurance is other than patient)  
 Full Name: \_\_\_\_\_

SSN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Relationship: \_\_\_\_\_

**Secondary Insurance**

Plan Name \_\_\_\_\_

Policy/Subscriber ID# \_\_\_\_\_

Group Number \_\_\_\_\_

Insured's Information  
 Check here if patient is primary member on plan.  
 (Only complete below if Primary on insurance is other than patient)  
 Full Name: \_\_\_\_\_

SSN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Relationship: \_\_\_\_\_



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### CONSENT FOR MEDICAL TREATMENT

I hereby consent to the procedures which may be performed during this examination, including services which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, and/or surgical treatments or procedures, anesthesia or other urgent services rendered to me under the general and special instruction of an Immediate Care of the South Physician.

### NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the notice of privacy practices, which describes the ways in which Immediate Care of the South may use and disclose my healthcare information for treatment, payment of services, healthcare operations and other described and permitted uses and disclosures.

### SELF PAY PATIENTS/NO INSURANCE COVERAGE

A \$150.00 standard fee is due before services are rendered. The \$150.00 payment is the standard fee. If charges exceed this amount, you will receive a statement with the excess charges in the mail. There will be no refund of the \$150.00 unless the patient leave before treatment. Otherwise, the full \$150.00 fee will go directly toward the office visit.

### PERSONAL PROPERTY AND VALUABLES

Personal property and valuables should be given to a family member. I understand that Immediate Care of the South is not responsible for any personal property or valuables, such as money, credit cards, jewelry, luggage, clothing, dentures, eyeglasses, hearing aids, or other prosthetic devices.

### AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the payment directly to Immediate Care of the South for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for any and all charges not paid by insurance, and for all services rendered on my behalf or my dependants. I authorize the doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

### FINANCIAL AGREEMENT

In consideration of the services rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, and agent or as the patient) individually promises to pay the patient's account at the rates established by the clinic for services provided. A receipt of charges for services to the patient is available upon request. All final charges are based on multiple factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

I hereby consent, acknowledge and fully understand the above. I also understand there are no guarantees or assurances from anyone as to the results that may be obtained from any medical treatment or services rendered at Immediate Care of the South.

X \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(PATIENT/GUARDIAN SIGNATURE)

Please give the nurse current medication list and allergy list.

Payment is due at registration.

How did you hear about us:  Walk/drive by  Newspaper  Family/Friend  
 Website  Facebook  Other

Thank you for choosing Immediate Care of the South!  
We look forward to participating in your healthcare.



## MEDICATIONS, ALLERGIES, HISTORY

### CURRENT MEDICATIONS (please list any vitamins or supplements you currently take)

MEDICATION	DOSE	TIMES PER DAY	MEDICATION	DOSE	TIMES PER DAY

### ALLERGIES TO MEDICATIONS OR OTHER AGENTS

ALLERGY	ALLERGY

### PAST MEDICAL HISTORY/FAMILY HISTORY (please check appropriate boxes)

Medical condition	Self	Mom	Dad	Sister	Brother	Son	Daughter
Arthritis							
Bleeding Problem							
Cancer							
Depression							
diabetes							
Epilepsy (seizures)							
GERD/Ulcers							
Hearing Problems							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Mitral Valve Prolapse							
Osteoporosis							
Stroke/TIA							
Thyroid Disease							
Tuberculosis							

### SURGICAL HISTORY

Appendectomy		CABG	
Cholecystectomy (gallbladder)		C-Section	
Hysterectomy		Tonsillectomy	
Other:			

**Smoker**       Yes     No    **How Long** \_\_\_\_\_ **Packs per Day** \_\_\_\_\_

**Alcohol**       Yes     No     Occasionally (1-2 Drinks Week)     Daily (1-2 Drinks Per Day)     Heavy (2 or more Daily)