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

Name: ☐ Male ☐ Female
Date of Birth: [redacted]
Mailing Address: Apt#:
City: State: Zip:
Home Ph#: Cell Ph#:
*Confidential Phone:
Home Email:
*Confidential Email:

Primary Care Physician (PCP):
PCP Address:
PCP Ph#:
[redacted]
Sexual Orientation:
Gender ID:

For more information on the confidential phone and email, please see the attached consent form.

EMERGENCY CONTACT INFORMATION

Name:
Relationship:
Home Ph#:
Cell Ph#:

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

What is your preferred language:
Race: ☐ I prefer not to answer
Ethnicity: ☐ I prefer not to answer
[redacted]
May we leave a message? [redacted]

[redacted]

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 #:

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. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. 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 also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

Signature Date

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.

Signature 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

Influenza Vaccination Record

Name: _____ D.O.B. _____

History of Allergies to egg or chicken products: ☐ YES ☐ No

History of Guillian-Barre Syndrome: ☐ YES ☐ No

History of hypersensitivity to previous vaccinations: ☐ YES ☐ No

Previous vaccination against Influenza Virus: ☐ YES ☐ No

Have you had any fevers recently? ☐ YES ☐ No

Have you had any recent illnesses? ☐ YES ☐ No

I request to be vaccinated against the influenza virus today. I have been informed of the potential side effects and risks associated with influenza virus vaccination.

X _____

PATIENT SIGNATURE

X _____ _____

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP TO PATIENT

SITE OF ADMINISTRATION: _____

DOSAGE: 0.5 ML INTRAMUSCULAR LOT/EXPIRATION: _____

ADMINISTERED BY: _____ Date Administered: _____

Vaccine Information Sheet provided to patient: ❑ YES ❑ No VIS Date: _____

CHILDREN BETWEEN 4-8 NOT PREVIOUSLY VACCINATED SHOULD RECEIVE A SECOND DOSE OF VACCINE 30 DAYS LATER