ACCESS MEDICAL CLINIC

PATIENT REGISTRATION FORM

PATIENT INFO:

Last Name: _____ First Name: _____ Middle Name: _____

Sex: ☐ male ☐ female Date of Birth: _____ SS#: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: _____ Language: _____ Race: _____

Ethnicity: ☐ not hispanic/latino ☐ hispanic/latino Preferred Pharmacy: _____

Patient or Guardian Email Address: _____

GUARDIAN INFORMATION (if required):

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ SS#: _____ Phone: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone: _____ Relationship to Patient: _____

NEXT OF KIN:

Name: _____ Phone: _____ Relationship to Patient: _____

EMPLOYER INFORMATION (if applicable):

Name: _____ Phone: _____ Occupation: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ ID#: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder SS#: _____ Policy Holder's Employer: _____

Secondary Insurance Company: _____ ID#: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder SS#: _____ Policy Holder's Employer: _____

CONSENT TO TREAT & RELEASE OF TREATMENT & ASSIGNMENT:

- I hereby voluntarily consent to the rendering of care and treatment by authorized members of Access Medical Staff, as they deem in their professional judgement to be necessary.
- I hereby assign my insurance benefits to be paid directly to Access Medical Clinic.
- I understand that I am financially responsible for all non-covered services, co-pays, deductibles, and/or coinsurance. I authorize and give my consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize Access Medical Clinic to release any medical information required to process claims.
- I authorize Access Medical Clinic to contact me by telephone and/or email to remind me of my appointments.
- I authorize Access Medical Clinic to download my medication history and immunization history.
- I am aware of the following Access Medical Clinic no-show policy:
  I may be charged $20.00 and/or terminated as a patient for any missed appointment that I do not cancel with at least 24 hours notice.

Responsible Party Signature: _____ **Date Signed:** _____