# Patient Registration Form

Please fill out form completely.

Patient's First Name: _____M.I._____ Last Name:_____

Date of Birth:_____ Sex: ❑Male ❑Female Social Security #:_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Address:_____City/State/Zip:_____

Home Phone:_____❑Okay to leave message/Cell Phone:_____❑Okay to leave message

Email:_____ Employer: _____

Emergency Contact: _____Relationship: _____Phone #_____

**Based on government regulations we are required to ask the following information**: ❑ I prefer not to answer

**Race:** ❑American Indian or Alaska Native ❑Asian ❑Black ❑Native Hawaiian or Other Pacific Islander ❑White ❑Other

**Ethnicity:** ❑Hispanic or Latino ❑Not Hispanic or Latino **Preferred Language**: _____

**Guarantor Information**: ❑Check if same as patient information. **Relationship to Patient:**_____

Name:_____ Sex: ❑Male ❑ Female Date of Birth: _____SSN:_____

Street Address:_____City/State/Zip:_____

*I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefit to this office.*

X: _____ Date: _____

**Patient/Guarantor Signature**

**Insurance Policy Holder**

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

Your relationship to the Policy Holder: ❑Child ❑Spouse ❑Other

**Authorization (Optional)**

By providing this authorization I release my Personal Health Information (PHI) to the following individual(s), I understand that the authorization is voluntary and is being done at my request. I understand that I also may refuse to sign this authorization and my treatment and/or payment obligation will not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy rules. I understand that I may revoke this authorization at any time by notifying Martin Medical Center in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for 1 year (1) until specified otherwise. I hereby authorize Martin Medical Center to use and disclose health information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**Consent for Treatment:** I, the undersigned, consent to the care and treatment by the attending physician, his/hers associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment. I also understand that Martin Medical Center is required to obtain records of my medication history.

I acknowledge that I have been given and have read the Notice of Privacy Practices for Martin Medical Center.

X: _____ Date: _____

**Patient/Guardian Signature**

*Pharmacy Name & Address:

_____

Living Will: For patients over the age of 18.

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|---|---|---|
| Do you have an Advanced Directive? | Yes | No |
| Would you like an Advanced Directive packet? | Yes | No |