

PATIENT REGISTRATION FORM (eCW)

(Please print)

PATIENT INFORMATION

Patient's Name: (Last) (First) (MI)

Address:

City, State, Zip:

Home: Cell: Work:

E-Mail Address: DOB:

Sex: Female Male Transgender

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Other Declined

Language: English Spanish Indian: Hindi, etc. Japanese Chinese Korean French German Russian Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined

Social Security Number:

RESPONSIBLE PARTY INFORMATION (If not self)

(Information used for patient balance statements)

Responsible party: Another patient Guarantor Self Check here if address and telephone information is same as patient

Responsible party name: (Last) (First) (MI)

Date of birth: MM/DD/YYYY Sex: Female Male

Social Security Number: Phone number:

Address:

City, State: ZIP:

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) (First)

Phone number: Do you have a living will? Yes No

Emergency contact relationship to patient: Guardian

Address:

City, State: ZIP:

Home phone: Work phone: Ext.

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: Date:

Printed name of patient or personal representative: Relationship to patient: