Patient Registration Form

PATIENT INFORMATION

Patient Information _____

Last Name: _____ First Name: _____ M.I.: _____

Mailing Address: _____ Apt# _____

City/State/Zip: _____

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

Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: If Voice, Please Select Preferred Number.

(Please Select Only One Option) Voice _____ Text _____ Home ___ Cell ____ Work____

Family Physician or Pediatrician: _____ Date of Birth: _____ / _____ / _____ Sex: Male ____ Female _____

Marital Status: _____ Social Security#: _____

Employer Name: _____ Emergency Contact Name: _____

Emergency Contact Phone#_____: Relationship to Patient: _____

ADDITIONAL INFROMATION

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor Last Name:

First Name: _____

Date of Birth: _____ Social Security#: _____ Phone: _____

Address of Person Responsible: _____ Relationship to Patient: _____

City/State/Zip: _____

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Can we leave a message regarding your medical care & test results? o Yes o No

Email Address: _____

Ethnicity (please select one): _____

Race (please select):

o 1/White o American Indian or Alaska Native o Asian

o Hispanic o Black or African American o Native Hawaiian or Pacific Islander

o Other o Decline

o Hispanic or Latino

o Not Hispanic or Latino

o Decline

o Indian (including Hindi & Tamil)

Preferred Language (please select one): o English o Bosnian o Russian o Spanish o Sign Language o Other _____

Preferred Pharmacy Name & Location: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to DrBoxerAtHome all money to which I am entitled for medical expenses related to the services performed from time to time by DrBoxerAtHome, but not to exceed my indebtedness to DrBoxerAtHome. I authorize DrBoxerAtHome to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims.

I choose to receive communications from DrBoxerAtHome by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

Signature of Responsible Party: _____

Printed Name of Responsible Party: _____

Date: _____ / _____ / _____