20311 Lappans Rd, ste 100
Boonsboro, MD 21713
301-799-1098
pvprimarycare@gmail.com

Patient Registration Form

Last Name_______________________________________ First Name_________________________MI_____

Preferred Name:__________________________________ Date of Birth________________ Biological sex (M / F)

Social Security Number:_________-_______-_______ Marital Status: ________________________________

Race: (circle one): African American/ Asian/ Asian Indian/ Black/ White/ Hispanic/ Decline to Specify

Mailing Address:____

Email Address:____

Home Phone:______________________________ Cell Phone:_______________________________

Employer_________________________________ Work Phone:______________________________

May we leave a detailed message on your answering machine? (Yes / No)

Emergency Contact, relationship & Phone:____

____

I authorize Pleasant Valley Primary Care to release my health information in the course of my examination and/or treatment to the following designated person(s):

Name:____________________________ Phone:____________________________Relationship:________________

Name: ____________________________ Phone: ____________________________Relationship:________________

Patient's Signature: ____ **Date**: ____________________________

ePrescribe Prescription History Consent

ePrescribing is a way for doctors to send electronically and accurate prescription from the doctor's office to the pharmacy. The ePrescribing Program also includes:

By signing this consent form you are agreeing to allow Pleasant Valley Primary Care to request your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Patient's Signature____ **Date:**____________________________

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