PHOENIX
HEALTH & WELLNESS

REGISTRATION FORM

PATIENT INFORMATION

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

Date of Birth: _____ /_____ /_____ Gender: Male Female
(Month) (Day) (Year)

Address: _____
(Street Address) (Apartment Number) (City) (State) (Zip Code)

Home #: _____ Cell #: _____

E-mail: _____ Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Widowed

Race/Ethnicity: ☐ White ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Other: _____

Contact Method: ☐ Home ☐ Mobile ☐ E-mail Language: ☐ English ☐ Spanish ☐ Other: _____

Employer Name: _____

Employer Address: _____
(Street Address) (Apartment Number) (City) (State) (Zip Code)

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____ Phone #: _____

PRIMARY INSURANCE

Insurance Name: _____

ID #: _____

Policy Holder's Name: _____

D.O.B: _____ /_____ /_____
(Month) (Day) (Year)

Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

SECONDARY INSURANCE (If Applicable)

Insurance Name: _____

ID #: _____

Policy Holder's Name: _____

D.O.B: _____ /_____ /_____
(Month) (Day) (Year)

Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

PHARMACY

Pharmacy Name: _____ Phone #: _____

Address: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I have read a copy of **South Shore Family Practice (Phoenix Health & Wellness Management Corp.)** Notice of Privacy Practices. Should I have any questions about the policy, I will discuss them with my Physician or the group's compliance team.

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

CONSENT TO TREATMENT

I hereby request and consent to diagnostic, therapeutic procedures and medical treatment by **South Shore Family Practice (Phoenix Health & Wellness Management Corp.)** as determined necessary in the professional medical judgment of my treating physician, including but not limited to electrocardiograms, blood tests, and administration of medications and vaccinations and obtaining e-script history, as applicable. I am aware that the practice of medicine and related procedures is not an exact science and I acknowledge that no guarantee as to the outcome of any procedures, treatments or examinations have been made to me.

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION TO SECOND PARTY

By signing below, I hereby give permission to **South Shore Family Practice (Phoenix Health & Wellness Management Corp.)** to discuss with the following individuals information related the health care services I receive at the above named physician's office/physician practice. I agree that this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information) prescription re-fill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this **does not** include the ability for the individuals noted below to authorize the disclosure of my protected health information to a third party or to request on my behalf a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice noted above.

Name of Individual _____ Relationship to patient _____ Phone #: _____

Name of Individual _____ Relationship to patient _____ Phone #: _____

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

GUARANTEE OF PAYMENT

As a self-patient, you are required to pay a fee of $25 for the nasal swab.

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date