ARCHANGEL MICHAEL HEALTH, PA

Patient Registration Form

Welcome to Archangel Michael Health!

Thank you for choosing us for your care. The following registration form helps us gather all the information we need to provide you with safe, effective, and personalized care. We understand it may seem lengthy, but each section is required to meet important legal, regulatory, and clinical guidelines. We appreciate your patience and cooperation as you complete these forms. Please be assured that all information submitted is stored securely in a HIPAA-compliant manner to protect your privacy.

Section 1: Patient Demographics

1. Last Name *

Single line text.

2. First Name *

Single line text.

3. Middle Name

Single line text.

4. Date of birth *

Archangel Michael Health currently only accepts patients aged 16 and older. Date.

5. Address *

Must have a Florida address. Single line text.

6. Cell Phone number *

Single line text.

7. Home Phone number

Single line text.

8. Preferred Phone number for practice communication *

Single choice.

- ○ Cell Phone
- ○ Home Phone
- ○ No Phone available/preferred

9. E-mail address *

Single line text.

10. Emergency contact information

Please provide Name, Relationship, Phone Number for your emergency contact. Multi Line Text.

11. Biologic/Birth Sex (for medical purposes) *

Single choice.

- ○ Female
- ○ Male
- ○ Prefer not to say

12. Optional Gender Identity (include any preferred pronouns)

We use this information to better provide you with affirming, respectful care. All information is confidential and governed by our HIPAA policies. If you prefer to discuss your gender identity and pronouns privately, you may indicate that here or during your visit.

13. Responsible Party

Required if patient is under 18 or has a legal guardian/power of attorney for healthcare. Multi Line Text.

14. I consent to receive communications from Archangel Michael Health regarding my care, scheduling, and account via the methods checked below. I understand that: *

Multiple choice.

☐ Text message: Primarily for appointment reminders & confirmations via the Athena Health system. Standard messaging rates may apply. SMS may not be fully secure.

☐ Email message: For appointment reminders/confirmations (via Athena Health system, with my permission), potentially for non-urgent clinical communication summaries (via secure practice email), practice updates/newsletters (optional, separate opt-out available), and billing information.

☐ Phone call: For direct communication with practice staff regarding clinical matters, scheduling, or urgent issues.

☐ Physical US Postal Service (USPS) mail: For formal documents, letters, or if other methods fail.

15. I understand that automated reminders (Text/Email) are managed through the Athena Health platform and I will be able to manage preferences via the Patient Portal, over the phone, or during the check-in process. I must consent to these forms of communication and will not be opted in automatically. *

Multiple choice.

☐ Yes

16. Please list all other Physicians, PCPs, Specialists, Provider Involved in your patient care? *

Multi Line Text.

17. Do you have any advanced directives, living wills, or durable power of attorney for healthcare? If yes, please elaborate. *

Multi Line Text.

18. Which language(s) are you most comfortable using for healthcare communication? *

Select all that apply. Multiple choice.

- ☐ English
- ☐ Spanish
- ☐ Mandarin
- ☐ Arabic
- ☐ Other

19. The patient demographic information provided above is current and accurate to the best of my knowledge *

Single choice.

- ○ Yes, it is
- ○ No, it isn't

By signing below, I confirm that all information provided is accurate and complete to the best of my knowledge.

Patient Name (Print):

Patient Signature:

Date:

All fields marked with an asterisk (*) are required.

Your information is protected under HIPAA regulations and kept confidential.