www.Facebook.com/healthmedUC**REGISTRATION FORM**

PLEASE FILL OUT FORM COMPLETELY

Today's Date:	Time:	PRIMARY CARE DOCTOR:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status:
Race:	Ethnicity:Preferred Language:		

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Birth date:	Age:	Sex: ◯ M ◯ F

Address:	City:	State:	Zip:

Social Security no.:	Home phone no.:	Cell phone no.:	Email Address:

How did you hear about us today (website (ex: google, yelp, yodel), newspaper, insurance, other) (if other explain)?

Please explain what brings you into the office today. If it is an injury please let us know if it is work, or car accident related.

INSURANCE INFORMATION

(Once done please give your insurance card to the receptionist.)

Insurance Carrier:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	ID no.:	Co-payment:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Summary Notice of Privacy Practice

The Following is a brief summary of your rights and our responsibilities as detailed in the Notice of Privacy Practices. This summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms.

1. Uses and Disclosures: We may use the Information we develop and collect for treatment by our practice or disclose the information to others whom we refer you to for treatment, payment, and certain health care "operations" such as improving competence and quality. We may disclose your information to transcription or billing services. We may call your home or mobile phone and may leave a message on your answering machine if you have one. We may disclose information to you or your family about your location, general condition or death. If you are available and able, we will ask your consent first. We will not disclose your information for marketing purposes without your written permission.

   Your medical information may be disclosed without your authorization as required by law, for public health purposes.

2. Other Uses and Disclosures: Except as described in the notice, we will no use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. Your Health Information Rights: You have a number of rights under the state and federal law which ar subject to the terms and condition specified in the Notice.

   a) You may request restrictions on certain uses and disclosures of your information.
   b) You may request that you receive your information from us in a certain way.
   c) You may inspect and request a copy of your medical records.
   d) You may request an amendment to anyrecord you believe is inaccurate.
   e) You may request an accounting of disclosures make of your records
   f) Authorization to release medical records to:

Please indicate the name of the individual or entity to whom you authorize release of your medical records, as well as their relationship to the patient.

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

Acknowledgment of Receipt of Notice of Privacy Practices

Print Name:	Signature:	Date: