PATIENT REGISTRATION

Patient Name:____

Date of Birth: _________________________ Sex: (circle one) Male -- Female

Street Address: ____

City, State and Zip Code: ____

Home Phone: ______________________________ Cell Phone: ______________________________

Primary Care Physician: ____

Office Number: ____________________________ Fax Number: _____________________________

Preferred Pharmacy: ____

Street Address: _____________________________________ City: ___________________________

Emergency Contact: Name: ____

Relation: ________________________________ Phone: ____________________________________

RECEIPT of PRIVACY PRACTICES: I acknowledge that I have received and read the Notice of Privacy Practices of Redi Care. Listed are the people I approve to receive my information.

Name: ____________________________________ Relationship: ____________________

RELEASE of RECORDS: I authorize Redi Care to release (verbal or in writing) confidential medical information to my Primary Care Physician, Medical Facility, including my Employer if treatment is related to employment purposes. I understand that my record is the property of my employer if this a work-related issue.

AUTHORIZATION for TREATMENT: I voluntarily consent to the administration and cost of medical and surgical procedures, x-rays and medications for myself and/or my dependents.

PAYMENT POLICY: We are a self-pay clinic. We do not file insurance. Payment is due in full at time of service.

PATIENT/GUARDIAN SIGNATURE:____

DATE: _________________ EMAIL: ____

EMAIL is Needed to Access our Patient Portal. This is an easy way to have access to your records.