Advanced Medical Center

Advanced Family Practice/Advanced Urgent Care
Existing Registration Form

NAME: _____ DATE: _____

PATIENT ADDRESS: _____ DATE OF BIRTH: _____
Street

_____ TELEPHONE#: _____
City, State, Zip

EMAIL: _____

INSURANCE: _____ MEMBER ID# _____

SUBSCRIBER: _____ SUBSCRIBER DATE OF BIRTH: _____

Subscriber ADDRESS: _____
(if not patient) City, State, Zip

PHARMACY: _____ PRIMARY PHYSICIAN: _____

PHARMACY LOCATION: _____
Street, City, State

Current Medications: _____

_____

Allergies and reactions: _____

LAST MENSTRUAL PERIOD: _____ ANY CHANCE YOU ARE PREGNANT? ☐ YES ☐ NO

XRAYS AND SOME MEDICATIONS CAN BE HARMFUL TO A FETUS. FOR THAT REASON, IT IS OUR POLICY TO PERFORM A PREGNANCY TEST ON ALL FEMALES AGES 15-45.

I AGREE TO A PREGNANCY TEST ☐ ***I OPT OUT OF A PREGNANCY TEST AT MY OWN RISK*** ☐

REASON FOR TODAYS VISIT:

_____

_____

_____

_____

_____

Emergency Contact: _____
Name Relationship Phone

Release and Use of Patient Information

In addition to the release and uses of my health information described in the HIPPA Notice of Privacy Practices, I authorize the release of my medical records, information, treatment and advice and specific health information to:

_____
Name Relationship Phone

Check Here ☐ if you choose the same person as your emergency contact.

I understand the information concerning medical care, advise or treatment may include: history, physical, diagnosis, laboratory and diagnostic testing, specific information concerning alcohol abuse, mental health, drug abuse, human immune-deficiency virus, hepatitis or other infectious diseases

I understand that I have the right to revoke this authorization

_____
Patient/Guardian/Guarantor Signature Date