Advanced
Medical Center

Advanced Family Practice
Existing Registration Form

NAME: _____

PATIENT ADDRESS: _____
Street Apt #

_____
City, State, Zip

DATE OF BIRTH: _____ TELEPHONE#: _____

Please provide the front office staff with a copy of your insurance card

OR

complete the insurance fields below:

INSURANCE: _____ MEMBER ID#_____

SUBSCRIBER: _____ SUBSCRIBER DATE OF BIRTH: _____

PHARMACY LOCATION: _____
Name

_____
Street, City, State, Zip

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

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

STAFF ONLY:

Updated and received by:

_____