TREMONT MEDICAL CENTER, PA **PATIENT REGISTRATION**

Welcome to our office. Have you or any of your family members been patients here before today? YES [ ] NO [ ]

If yes: Name of Family Member:_____ **Date of Birth:**_____

How were you referred to our office?_____

IF THIS IS A WORK RELATED INJURY, PLEASE NOTIFY THE RECEPTIONIST NOW.

PLEASE PRINT ANSWERS TO ALL QUESTIONS.

You will be asked to provide photo ID. All information will be strictly confidential.

PATIENT NAME: LAST FIRST MI	SSN: - -
ADDRESS: CITY STATE ZIP CODE HOME PHONE: CELL PHONE:	DATE OF BIRTH: / / SEX: M [ ] F [ ]
IF OUT OF TOWN, PLEASE PROVIDE LOCAL CONTACT INFORMATION: NAME: PHONE:	
EMPLOYER NAME: WORK PHONE: ADDRESS: EXTENSION:	
REASON FOR TODAY'S VISIT:	REGULAR PHYSICIAN: PHONE: LAST VISIT:

If patient is under 18, please fill out the following completely.

RESPONSIBLE PARTY NAME: LAST FIRST MI	SSN: - -
ADDRESS : CITY STATE ZIP CODE HOME PHONE: CELL PHONE:	DATE OF BIRTH; / / RELATIONSHIP TO PATIENT:
EMPLOYER NAME: WORK PHONE: ADDRESS: EXTENSION:	

PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE.

I authorize Tremont Medical Center, P.A. to perform appropriate medical procedures as deemed necessary. I also understand Tremont Medical Center serves as an alternative to the hospital emergency department providing routine medical care and minor emergency treatment. It cannot provide the comprehensive care of a private physician. Therefore, I may be released before all of my medical or surgical conditions are known or treated.

_____ _____

PATIENT OR PARENT/GUARDIAN (if patient under 18 years old) **DATE**

I have been offered a written copy of the Privacy Practice Notice for Tremont Medical Center.

_____ _____

PATIENT OR PARENT/GUARDIAN (if patient under 18 years old) **DATE**