Southern Illinois Family Medicine

PATIENT REGISTRATION - P1

PLEASE PRINT Today's Date _____ SSN _____

PATIENT NAME _____ DOB _____

ADDRESS _____ APT _____

CITY _____ STATE _____ ZIP _____

MALE _____ FEMALE _____ Marital Status _____

HOME# _____ WORK# _____ CELL# _____

*Email_____ Pharmacy_____ City _____

Do you smoke yes ☐ or _☐_ no Full-time Student ☐ Part-time ☐ Not a Student ☐

*Can we mail information to the above address about appointment and/or test results YES☐ NO☐

PHONE # WHERE DR. CAN REACH YOU _____

EMERGENCY CONTACT NAME _____ PHONE _____

EMERGENCY CONTACT

ADDRESS _____ RELATIONSHIP _____

PARENT GUARDIAN NAME (for pediatric patients) _____

----------GUARANTOR INFORMATION----------

PERSON RESPONSIBLE FOR INSURANT (guarantor) _____

ADDRESS (if different from above) _____

RESPONSIBLE PARTY PHONE _____ DOB_____ SS#_____

RELATIONSHIP PATIENT _____ EMPLOYER _____

OCCUPATION _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

I hereby consent to the medical treatment as ordered by my medical provider or their designees. I authorize the release of medical information to process payment on my account. I authorize payment of medical benefits directly to the provider of service. I understand I will be Responsible for the unpaid balance of my account. I certify that the information is correct.

SIGNATURE _____ DATE _____

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I, _____ acknowledge that I have receive a copy of the Privacy Notice from Southern Illinois Family Medicine, and I understand it is my responsibility to read the notice and ask questions as necessary.

_____ _____

Patient Signature/Patient Representative Date

_____ _____

Relationship to Patient Date

_____ _____

Witness Date

The undersigned consents to Southern Illinois Family Medicine releasing his/her medical information to the following individuals:

_____

Name to receive Info & Relationship to Patient

_____

Name to receive Info & Relationship to Patient

_____

Name to receive Info & Relationship to Patient

SIGNED _____ DATE _____

*This consent may be revoked at any time upon written request

REFUSAL TO SIGN RELEASE OF INFORMATION TO FAMILY MEMBER

_____

Patient Signature Date

*** **NO SHOW POLICY** ***

To better serve you, please call 24hours/or 2 hours (in an emergency) in advance if you are unable to keep your Appointment so we can allocate the time slot for other patients. If you do not show up to your appointment without Prior notice, there will be a 25.00 fee assessed to your account. This will have to be paid before your next appointment time, **If you no show more than two times, you will automatically be discharged from our practice due to liability and noncompliance issue.** I have read and understand the NO SHOW policy as written above.

*** **LAB POLICY** ***

Due to possible occasional miscommunication between your lab and imaging center, we may not get your test results back in time. Please **DO NOT** assume that your results are normal, unless you have confirmed with our office. It is your responsibility to call our office for your test results, if you do not receive any phone calls from our office after one week from the original date of your testing. It is our policy to call every patient for rest results regardless of normal or abnormal findings.

I have read and understand the above announcement and acknowledge that it is my own personal responsibility to call for test results if I do not hear any results within 7 business days of my original testing.

Thank You, for your cooperation.

Sign _____ Date _____