Southern Illinois Family Medicine

PATIENT REGISTRATION - P1

PLEASE PRINT Today's Date _	SSI	N	
PATIENT NAME		DOB	
ADDRESS		APT	
CITY	STATE	ZIP	
MALE FEMALE	Marital Statu	s	
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 th	e above address about appoint	tment and/or test results YES NO	
PHONE # WHERE DR. CAN REAG	CH YOU		
EMERGENCY CONTACT NAME _		PHONE	
EMERGENCY CONTACT			
ADDRESS		RELATIONSHIP	
PARENT GUARDIAN NAME (for	pediatric patients)		
	GUARANTOR INFORMAT	TON	
PERSON RESPONSIBLE FOR INS	URANT (guarantor)		
ADDRESS (if different from abo	ve)		
		3SS#	
		EMPLOYER	
CITY		ZIP	
I hereby consent to the medical tr	eatment as ordered by my medica	al provider or their designees. I authorize	
		unt. I authorize payment of medical sponsible for the unpaid balance of my	
account. I certify that the information		sponsible for the unpaid balance of my	
SIGNATURE		DATE	

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I,acknowledge	that I have receive a cop	y of the Privacy Notice from Southern
Illinois Family Medicine, and I understand it is necessary.	s my responsibility to rea	d the notice and ask questions as
Patient Signature/Patient Representative		Date
Relationship to Patient		Date
Witness		Date
The undersigned consents to Southern Illinois following individuals:	Family Medicine releasi	ng his/her medical information to the
Name to receive Info & Relationship to Patien		
Name to receive Info & Relationship to Patien		
Name to receive Info & Relationship to Patien	nt	
SIGNED DATE		
*This consent may be revoked at any time up	on written request	
REFUSAL TO SIGN RELEASE OF INFORMATION	N TO FAMILY MEMBER	
Patient Signature	Date	
*** NO SHOW POLICY ***		
To better serve you, please call 24hours/or 2 hours Appointment so we can allocate the time slot for onotice, there will be a 25.00 fee assessed to your a you no show more than two times, you will auton noncompliance issue. I have read and understand	other patients. If you do not ccount. This will have to be matically be discharged from	show up to your appointment without Prio paid before your next appointment time, It n our practice due to liability and
*** LAB POLICY ***		
Due to possible occasional miscommunication betwin time. Please DO NOT assume that your results a responsibility to call our office for your test results from the original date of your testing. It is our policindings.	re normal, unless you have , if you do not receive any p	confirmed with our office. It is your hone calls from our office after one week
I have read and understand the above announcem test results if I do not hear any results within 7 bus	_	
Thank You, for your cooperation.		
Sign	Date	