ATLAS MEDICAL CONSULTANTS

Patient Registration Form

Personal Information

Last Name:_____First Name:_____Sex:_____

Date of birth:_____ Social Security Number:_____

Address:_____City:_____ State:_____

Zip Code:_____ Home # ( ) _____- _____ Cell Phone # ( ) _____-_____

Email address:_____ Preferred Contact: Home Cell Work Email Mail

Preferred Language:_____Race:_____Ethnicity: Hispanic Not Hispanic

Marital Status: Married Divorced Single Widowed Other

Referring Doctor:_____ Phone # ( )_____-_____

Primary Care Doctor:_____ Phone # ( )_____-_____

Pharmacy:_____ Address:_____

Do you reside in a Skilled Nursing Facility? Yes No

Name of facility:_____ Address:_____

CONTACT IN CASE OF EMERGENCY

Name:_____ Relationship:_____ Phone # _____

The following person(s) are authorized to have access to billing, appointment and treatment information. (Person responsible for account must be listed.)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I hereby accept responsibility for the cost of this exam or treatment in the event my insurance company denies a claim.
I hereby accept and agree to accept responsibility of the cancellation policy of this office: Giving 24 hour notice to cancel:
If I am unable to comply, a $50.00 fee will be charged to my account.

Signature:_____ Date:_____