Eastside Medical Group
Patient Registration Form

PATIENT INFORMATION (Please Print)

Patient's Name (Last) ________________ (First) __________ (MI) ____ Previous Name ________________

Address ____

City, State ____________________ ZIP__________

Home Phone ______________ Cell No. ______________ Work Phone ____________Ext. ________

E-Mail Address:________________________________

Date of Birth MM ______/DD ________/YYYY __________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Social Security Number____________________

Race/Ethnicity ☐Asian ☐ Black or African American ☐ Caucasian ☐ Hispanic or Latino
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Declined

Language ☐ English ☐ Spanish ☐ Other ____________________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Primary Care Provider (PCP) ______________ Referring Provider ____________________

Pharmacy ________________________________ Pharmacy Phone ____________________

Employment Status ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military

Emergency Contact Last Name ____________________ First Name ____________________

Phone Number ____________________ Relationship to Patient ____________________

RESPONSIBLE PARTY INFORMATION ☐ Self (information used for patient balance statements)

Responsible Party Name (Last) ________________ (First) ________________ (MI) ________

Date of Birth MM _____/DD __________/YYYY ______________ Sex ☐ F – Female ☐ M - Male

Social Security Number ______-________-_______ Telephone ____________________________

(If different from patient) Address ____________________City, State ______________ ZIP ____

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

How did you hear about us?

☐ Website ☐ Internet Search ☐ Internet Advertisement ☐ Family/Friends ☐ Facebook ☐ Magazine/Newspaper Ad
☐ Another healthcare provider: ____________________ ☐ Physician Directory ☐ Hospital MD Referral – Medline

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you, If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions, I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: ______________________________ Date: ________________

Printed name of patient or personal representative: ______________________________ Relationship to patient: ____________