Texting:☐Email: ☐
Portal: ☐

PATIENT REGISTRATION FORM (INVERNESS SURGICAL ASSOCIATES)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First) _____(MI)___Previous Name _____

Address:_____

City, State, Zip:_____

Home Phone Number:_____ _____Cell: _____Work:_____

Date of Birth:_____E-Mail Address:_____ _____

Patient Social Security Number: _____

Gender Identity: ☐ Female ☐Male ☐ Transgender ☐Choose not to disclose ☐ Other _____

Race: ☐Black/African American ☐Hispanic ☐White ☐ Choose not to disclose ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐Choose not to disclose

Preferred Language: ☐English ☐Spanish ☐ French ☐Other not listed_____

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

Employment Status: ☐Full-Time ☐Part-Time ☐Not Employed ☐Self-Employed ☐Retired ☐Other_____

PRIMARY CARE DOCTOR: _____

PHARMACY NAME & LOCATION: _____

HOW DID YOU HEAR ABOUT US? Internet___ Hospital____ PCP___ Friend/Family___Newspaper____Other____

Do you have a living will? ☐Yes ☐No

RESPONSIBLE PARTY INFORMATION (If not self) :

☐Check here if address and telephone information is same as patient

Responsible party name: (Last)_____ (First)_____ (MI)____

Date of birth: MM___ /DD___ /YYYY____ Sex: ☐Female ☐Male ☐Other_____

Responsible Party Social Security Number: _____ Phone number:_____

Address: _____City:_____ State:___ ZIP:_____

EMERGENCY CONTACT INFORMATION:

Emergency contact name: (Last)_____ (First)_____

Phone number:_____ Emergency contact relationship to patient:_____

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: _____

Printed name_____ **Date:**_____