NEW PATIENT REGISTRATION FORM

PLEASE PRINT AND COMPLETE ALL SECTIONS BELOW

Today's Date:			
Referred By:			
Patient's Name:			
Date of Birth:	Age:	Single/Married/Divorced/Seperated/Widowed	
M ___ F ___	Social Security #	Driver's License #	
Street Address:			
City, State, Zip:			
Phone (home):	Phone (cell):		
E-mail:	Race:	Primary Language:	
IN CASE OF EMERGENCY			
Emergency Contact:	Relationship to patient		
Street Address:			
City, State, Zip:			
Phone (home):	Phone (cell):		
EMPLOYMENT INFORMATION			
Employer:	Occupation:		
Street Address:			
City, State, Zip:			
Phone:	Work Email:		
PHARMACY INFORMATION			
Pharmacy Name:	Phone:		
Street Address:			
City, State, Zip:			

MEDICATIONS (Prescribed and Over the Counter)		
Drug Name	**Strength**	**Frequency taken**

DRUG ALLERGIES, if any

CONSENT TO TREAT

I, the undersigned voluntarily give consent to my Katy Medical Center medical professional to provide and perform such medical/diagnostic/minor surgical treatment (s) and/or services as deemed advisable and necessary for the disgnosis and/or treatment of my condition (s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ _____

Patient signature Date

RECEIPT OF OFFICE POLICIES & PROCEDURES AND PRIVACY NOTICE

I have received/reviewed a copy of the Katy Medical Center "Office Policies and Procedures for Our Patients" and "Notice of Privacy Practices" and the Texas Patient Bill of Rights.

_____ _____

Patient signature Date

Release of Health Information

1. Katy Medical Center and its staff adhere to a policy of not releasing protected health information to individuals other than the patient. If you choose, you can designate others to receive your health information (check or put N/A below).

_____ I authorize Katy Medical Center to release protected healthcare information about myself to the following individual:

Name: _____ Relationship: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

2. The Texas Department of State Health Services (DSHS) consolidates immunization records for public health purposes and encourages your voluntary participation in the Texas Immunization Registry. More information can be found at www.ImmTrac.com (check or put N/A below).

_____ I authorize Katy Medical Center to register and release my immmunization records to authorized persons/entities

_____ _____

Patient signature Date