FirstHealth Infectious Diseases

PATIENT REGISTRATION

Patient Information	Emergency Contact Information
Last Name:	Name:
First Name:	Relation:
Middle Name:	Phone: ( )
Sex:	
Date of Birth:	**Patient's Employer**
Social Security:	Company Name:
Street Address:	Company Phone: ( )
or PO Box#:	
Zip Code:	**Guarantor Information**
City:	*Name to whom statements are sent if other than patient.*
State:	Last Name:
Home Phone: ( )	First Name:
Work Phone: ( ) Cell Phone: ( )	Middle Name:
Email Address:	Street Address:
Marital Status:	PO Box#:
Guardian Information	Zip:
Last Name:	City:
First Name:	State:
Middle Name:	
Please present your insurance Policy Cards for Photocopying	
Enter Policy Holder's Date of Birth	Employer:

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical information necessary to process claims for services rendered by FirstHealth Infectious Diseases. I permit a copy of this information to be used in the place of the original.

Signature:_____ Date:_____
Patient or Responsible Party

I hereby authorize the providers of FirstHealth Infectious Diseases to apply for benefits on my behalf for covered services rendered or ordered by them. I request that payment from my Insurance Company be made directly to the provider. I certify that the information I have reported with regards to my Insurance coverage is correct. I permit a copy of this authorization to be used in place of an original. Regardless of my contract with my insurance carrier, I understand I am ultimately responsible for this bill.

Signature:_____ Date:_____
Patient or Responsible Party

I hereby acknowledge that I have received the FirstHealth Notice of Privacy Practices. I hereby authorize the providers of FirstHealth Infectious Diseasesto treat/manage my healthcare and make referrals as necessary. I also acknowledge that this clinic does not accept or respond to patient initiated emails. **I hereby authorize the providers of the FirstHealth Infectious Diseases to obtain my last two years of medication history by electronic download, to treat/manage my healthcare and make referrals as necessary.**

Signature:_____ Date:_____
Patient or Responsible Party