South Palm
Family Center
1701 Hillmoor Drive, Suite 9
Port St Lucie, FL 34952
TELEPHONE: 772-348-0303
FAX: 772-348-0307

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient's Legal Name: _____

Last First M.I.

Social Security Number: _____ - _____ - _____ Date of Birth: _____/ _____/ _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip Code: _____

Phone Number (Cell): _____ Home: _____ Work: _____

E-Mail Address:_____

Gender (Please check one): ☐ Female ☐ Male ☐ Other (specify): _____ ☐ Do Not Wish to Disclose

Race (Please check one): ☐ White ☐ Black/African American ☐ American Indjan/Alaskan Native ☐ Asian

☐ Native Hawaiian/Other Pacific Islander ☐ Other (specify): _____

☐ Do Not Wish to Disclose

Ethnicity (Please check one): ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Do Not Wish to Disclose

Language Spoken (Please circle all that apply): English Spanish Japanese Mandarin Korean French Russian Arabic

Hindi, Tamil, Gujarati etc. Swahili Vietnamese Creole Burmese Albanian

Bosnian/Croatian/Serbian/Serbo-Croatian Tagalog Portuguese Cambodian

Farsi-Iranian/Persian ASL Other not listed (specify): _____

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TELEPHONE: 772-348-3303
FAX: 772-348-3307

RESPONSIBLE (GUARANTOR) PARTY INFORMATION (*If not self*) INFORMATION IS USED FOR BILLING PURPOSES

Responsible Party's Legal Name: _____

Last First M.I.

Responsible Party's Social Security Number: _____ - _____ - _____ Date of Birth: _____/ _____/ _____

Address (if different from patient): _____

City, State, Zip Code: _____ Phone Number (Cell): _____

****INSURANCE INFORMATION: PLEASE PROVIDE ALL INSURANCE CARD(S) TO FRONT DESK STAFF AT CHECK-IN****

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Phone Number: _____

Emergency Contact Relationship to Patient: _____

Do you have a living will? ☐ YES ☐ NO

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 healthcare 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 representative: _____ Date: _____

Name of patient or representative (please print): _____ Relationship to patient: _____