

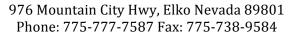
976 Mountain City Hwy, Elko Nevada 89801 Phone: 775-777-7587 Fax: 775-738-9584

## **New Patient Registration Form**

				Ple	ease F	Print					
Today's Date											
			PA	TIENT I	INFO	ORMA'	TIO	N			
Social Security #:			Full Legal Name: (First)						Middle)		
Date of Birth:  Sex:  Male				□ Female □							
Mailing Address:			Zip					City:		State:	Country:
Home Phone #:	Phone #: Cell Phone #:				Email:						
Information/Marketing Information: Yes □ No □						Patient Reminders Communication:  Yes  No					
Preferred Method of Communication:  Email  Home Phone  Cell Phone						How did you hear about A+ Total Care? Billboard □ Facebook □ Newspaper □ Family/Friend □					
Marital Status: Child  Single  Married  Separated  Divorced  Widowed											
Employer Name:					Employer Phone #:						
Employment Status: Student											
			ADDI	TIONA	LIN	FORM	ATI	ION			
Primary Care Physician:					I	Referrin	g Phy	ysician:			
			EM	1ERGEN	NCY	CONT	ACT				
Full Legal Name: (First) (Last) (Middle) Relationship to Patient:									ent:		
Mailing Address:			Zip:		):	City:			State:	Country:	
Primary Phone #:						Email:					
				DEMO	GR/	APHIC	S				
Race: American Indian/A Ethnicity: Hispanic or La			ian   Black,  Banic or Latin		Amer	rican 🗆	Nat	ive Hawaiian/I	Pacific Isla	nder 🗆 W	hite □
Preferred Language: Eng	lish 🗆 Sp	panish									
			POLICY			INFOR	MA'	TION			
Full Legal Name: (First)	(	(Last)		(Mido							
Mailing Address:					Zip:			City:		State:	Country:
Social Security #: Date of Birth:				Sex	Sex:  Male  Female			R	Relationship to Patient:		
				RANTO		_		_			
			rson Financia			e if Insur	ance	Does Not Pay)			
Name: (Last)	(First	:)		(Middle)				<u></u>		_	
Mailing Address:					Zip:			City:		State:	Country:
Phone #:	Social Security #:			Date of Birt				ale 🗆 Female 🗆		Relationship to Patient:	

I acknowledge that I have read and received <u>or</u> declined a copy of the "Patient Financial Responsibility", "Patient Rights Regarding Medical Records", and the "Confidentiality and Privacy of Medical Records". I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient/Guardian Signature:	Date:





## **Consent Information**

You expressly consent and agree that, in order to discuss or service your account(s) (the "Accounts") or to collect amounts you may owe, A+ Total Care, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Patient/Guardian Signature:
Relationship:
Consent of Notification of Test Results
I give permission to A+ Total Care to notify:
Relationship:
I give permission to A+ Total Care to leave any health information on my voicemail.
Patient/Guardian Signature:
Relationship: