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

New Patient Registration Form

Please Print

Today's Date_____

PATIENT INFORMATION

Social Security #:	Full Legal Name: (First) (Last) (Middle)			
Date of Birth:	Sex: Male □ Female □			
Mailing Address:	Zip:	City:	State:	Country:
Home 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 □ Not Employed □ Part Time □ Full Time □ Divorced □ Self Employed □ Retired □ Disabled □				

ADDITIONAL INFORMATION

Primary Care Physician:	Referring Physician:

EMERGENCY CONTACT

Full Legal Name: (First) (Last) (Middle)			Relationship to Patient:	
Mailing Address:	Zip:	City:	State:	Country:
Primary Phone #:	Email:			

DEMOGRAPHICS

Race: American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian/Pacific Islander □ White □

Ethnicity: Hispanic or Latino □ Not Hispanic or Latino □

Preferred Language: English □ Spanish □

POLICY HOLDER INFORMATION

Full Legal Name: (First) (Last) (Middle)				
Mailing Address:	Zip:	City:	State:	Country:
Social Security #:	Date of Birth:	Sex: Male □ Female □	Relationship to Patient:	

GUARANTOR INFORMATION

(Person Financially Responsible if Insurance Does Not Pay)

Name: (Last) (First) (Middle)				
Mailing Address:	Zip:	City:	State:	Country:
Phone #:	Social Security #:	Date of Birth:	Sex: Male □ Female □	Relationship to Patient:

I acknowledge that I have read and received or 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:*** _____

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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:_____