



**ESTABLISHED PATIENT REGISTRATION FORM**

Today's Date: \_\_\_\_\_

*Please Print*

<b>PATIENT INFORMATION</b>				
Full Legal Name: (First)		(Last)	(Middle)	
Date of Birth:	Has your address, email, or phone number(s) changed since last visit? No <input type="checkbox"/> Yes <input type="checkbox"/> <i>(please update address and/or phone number(s) below)</i>			
Mailing Address:		Zip:	City:	State: Country:
Home Phone #:	Cell Phone #:	Email:		
Marital Status: Child <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>				
Has your insurance changed since last visit? No <input type="checkbox"/> Yes <input type="checkbox"/> <i>(please present new insurance card to front desk personnel)</i>				
<b>EMERGENCY CONTACT</b>				
Full Legal Name: (First)			(Last)	(Middle) Relationship to Patient:
Mailing Address:		Zip:	City:	State: Country:
Primary Phone #:		Email:		



### 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: \_\_\_\_\_