

Patient Registration
DMH Express Care / The Clinic at Walmart

PATIENT

Full Legal Name _____ Soc Sec # _____

Mailing Address _____ Birth date ____/____/____

Street Address _____

City _____ State _____ ZIP _____

Sex: Male Female Race _____ Ethnicity _____ Preferred Language _____

Marital Status: Single Married Separated Divorced Widow(er)

Family Physician _____ Referring Physician _____

Home Ph (____) _____ Work Ph (____) _____ Cell Ph (____) _____

E-Mail _____ May we e-mail you at this address? Yes No

Preferred Method of Contact: (**circle one**) Home Work Cell Email

Work Status: Full-time Part-time Retired Not Employed Student Status: Full-time Part-time

Employer _____ Is this a work injury? Yes No Accident? Yes No

Emergency Contact Name _____ Emergency Contact Phone (____) _____

PERSON RESPONSIBLE FOR PAYMENT Please complete if **not** the same as the patient.

Full Legal Name _____ Relationship to Patient _____

Home Phone (____) _____ Work Ph (____) _____ Cell Ph (____) _____

Street Address _____

City _____ State _____ ZIP _____

E-Mail _____ May we e-mail you at this address? Yes No

FIRST (PRIMARY) INSURANCE Complete this section with insurance **card holder** data.

Name of Insurance Company _____

Card holder name **exactly** as shown on card _____

Soc Sec # _____ Birth date ____/____/____ Sex: Male Female

SECOND (SECONDARY) INSURANCE Complete this section with insurance **card holder** data.

Name of Insurance Company _____

Card holder name **exactly** as shown on card _____

Soc Sec # _____ Birth date ____/____/____ Sex: Male Female

HOW YOU LEARNED ABOUT OUR PRACTICE Other than your physician, what influenced your decision to come to this practice? Please check only **one** box:

- Billboard Brochure / Flyer DMH Newsletter DMH Website Employer Family / Friend
 Magazine Ad Newspaper Radio TV Yellow Pages Heard Recorded Message
-

SIGNATURE

DATE

X _____

Consent for Treatment

DMH Express Care / The Clinic at Walmart

Patient's Full Legal Name _____

Birthdate (mo/day/year) ____/____/____ Social Security # _____

1. **Consent for Treatment** I am asking for and consent to receive care from DMH Express Care / The Clinic at Walmart and its health care providers. I understand this care may include [1] diagnostic procedures (which may include laboratory tests and X-ray examinations) and [2] medical and surgical treatment. I permit the health care providers, their associates and assistants, and their employees to provide me with services which are considered necessary or advisable. No guarantees have been made to me about the outcome of this care. In the event I decide to refuse the recommended treatment considered necessary or advisable by the health care providers, I relieve DMH Express Care / The Clinic at Walmart and its health care providers of all responsibility for any ill effects which might result from my action.

I acknowledge that I have read the consent for treatment and conditions listed above and further acknowledges that I am the patient or am duly authorized by the patient as a legal representative to execute and accept the terms as set forth herein.

2. **Other** I permit a copy of this consent to be used in place of the original. This consent shall remain in effect until rescinded in writing. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to DMH Express Care / The Clinic at Walmart or its health care providers.

If you are **not** the patient, please specify your **relationship** to the patient: _____

X _____
Signature of Patient (or Legal Guardian if Patient is a Minor) *Date*

X _____
Signature of Guarantor (Person Responsible for Payment) *Date*

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Letter

I, _____, hereby give my consent to
(Name of Patient or Authorized Agent)

DMH Express Care / The Clinic at Walmart to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

You have my permission to release medical/financial information to:

Name	Relationship

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient
_____.