Patient Registration Form

Patient Information		
Legal First Name:	Middle Name:	Last Name: Suffix:
Preferred Name (if applicable):	MUNIS # (if applicable):	
Date of Birth:	Social Security #:	Sex: Male or Female
Mailing Address: Apt # :		
City/State/Zip:	Personal Email:	
Home Phone:	Cell Phone:	Work Phone: ext:
Preferred method of communication Phone: home cell work	Primary Care Provider's name / contact #:	

In Case of Emergency, call :	Name:	Relationship to patient:	Phone:

May Onsite Employee Health and Wellness release medical information to specified person other than you? YES NO
If yes, please specify to whom this information may be released:
Authorized Person Name: Relationship to patient:

If we need to contact you regarding an appointment, may we leave a message on your voicemail? YES NO
If we need to contact you regarding lab or test results, may we leave a message on your voicemail? YES NO
If we are unable to reach you by phone, may we mail results to your home? YES NO

CMCSS / County Employee and Insurance Information (Please present insurance card or indicate payroll deduction)

Employer Information: CMCSS or Montgomery County	Who is employed? Self Spouse Parent
Position/Title:	School/Department:

BCBS Select Subscriber or Payroll Deduction (circle one)
PLEASE NOTE: (The $40 payroll deduction option is for employees **only**; does not include any additional costs of medications, labs, or procedures that may be required.) **Important Info:** Onsite Clinic Providers are not registered Tenncare Providers. Due to this fact, please be aware that Tenncare patients and any medications prescribed to them risk being turned away at the pharmacy.

Employee/Subscriber's Legal Name:		
Subscriber ID #/CKR:	Subscriber SSN:	Subscriber Phone:
Subscriber address:	Subscriber's DOB:	
Preferred Pharmacy:		

***IF THE PATIENT IS A MINOR (under the age of 18), please fill out the Responsible Party* Information.** **The parent or guardian bringing the patient in will be listed as the responsible party if this area is left blank.**

First Name:	Last Name:	Relationship to Patient:
Mailing Address: Apt #		
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone: ext:

If patient is a minor child under 18 years of age and you as a parent or legal guardian are not able to accompany your child to their appointment, who is able to accompany and authorize patient care?
Authorized Person Name: Relationship to patient:

Do you authorize your child to be seen without a parent/guardian in attendance? YES NO

I understand that Onsite Employee Health and Wellness keeps on premises a copy of the "Notice of Privacy Practices for Protected Health Information," which provides a more complete description of the uses and disclosures of my medical records, and that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me upon request. I understand there is a $20 payroll deduction to the primary subscriber for all appointments cancelled less than 2 hours prior to the schedule appointment or if a patient no-shows to the scheduled appointment. I also understand that this form needs to be completed upon the request of Onsite Medical and / or yearly. I understand this document is part of my permanent medical records and I make updates in writing requesting changes.

____ ________/_________/________

Patient Signature (Parent/Legal Guardian) Date