

Clinic Patient Registration Form

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Date: _____

Patient Registration

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS			
CITY, STATE		ZIP	HOME PHONE		CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
PATIENT EMPLOYER NAME		PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)			EMPLOYER PHONE
PARENT / LEGAL GUARDIAN INFORMATION			RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian		
NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER	
CURRENT PRIMARY CARE PROVIDER INFORMATION					
PRIMARY DOCTOR/FAMILY DOCTOR			REFERRING DOCTOR		
IN CASE OF EMERGENCY CONTACT			RELATIONSHIP	PHONE NUMBER	

Authorization to release health information to:					
Name(s)			ADDRESS		
CITY, STATE			ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE			AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)		
FROM:	TO:	<input type="checkbox"/> NEVER DATE:			
Release the following information:					
<input type="checkbox"/> All Records		<input type="checkbox"/> Chart Notes		<input type="checkbox"/> Radiology Reports	
			<input type="checkbox"/> Operative Reports		<input type="checkbox"/> History & Physicals

RELEASE OF INFORMATION		
I understand that:		
<ul style="list-style-type: none"> once clinic discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information. I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524). my records are protected and cannot be disclosed without written permission this Authorization will remain in effect for unlimited time or I provide a written notice of revocation to the Medical Record Department. 		
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT		SIGNATURE OF WITNESS (Optional):

