Internal Medical Center

Date:_____

ESTABLISHED PATIENT VISIT REGISTRATION & CONSENT

OFFICE USE ONLY
#

Time In: Time to Box:

AMT PD $
Cash Ck CC

By:

Patient Name **Date of Birth**

Street Address **SSN**

City **State** **Zip**

Home Tel # **Cell Tel #**

Employer **Work Tel #**

Emergency Contact Name: **Emergency Contact Tel #**

Insurance Company **Email address**

Please explain in detail what you are being seen for today:

Please list your Pharmacy, their address and phone number:_____

Medications currently prescribed (use back of side of page for additional space, if needed)

Medication	Dosage	Directions	Prescribed by

Medication Allergies

Medication	Reaction	Medication	Reaction

Previous Surgeries/Hospitalizations

Date	Surgery	Date	Surgery

Are you under the care of any other Physician?

Physician	Treating Condition	Physician	Treating Condition

I, the undersigned, hereby acknowledge that original authorizations and/or consents that were previously signed are applicable to these services in regards to Consent for Treatment, Authorization for Assigned Benefits or Financial Default.

Signature of Patient_____ **Witness**_____

Signed for Patient By:_____ **Relationship:**_____