The HomeTown Doctors, PA

New Patient Registration

(Please print clearly)

Patient's Legal Name _____ **LAST 4 DIGITS** SSN: _____

Sex: _____ Birth date _____ Patient Marital Status _____

If patient is a minor, name of legal guardian: _____

Home Address: _____

Is mailing address same? ___ Yes ___ No

Mailing Address _____

(if different) _____

Patient Cell Phone Number (_____)_____- _____ Home Phone Number (_____)_____- _____

Who is legally authorized to make patient's healthcare decisions?

_____ Self/Patient _____ Parent/Legal Guardian/Parent _____ Healthcare Representative (POA)

Does patient (or guardian/representative) use email? Yes ____ No ____

Email address: _____

Please read and initial the appropriate spaces below to give your consent to contact methods.

If physicians* from The Hometown Doctors need to contact me by telephone or email, I am aware and understand they may need to share my personal health information in their communication. I hereby authorize physicians of this practice to contact and leave messages for me in the following manner:

_____ *(Please Initial)* *DO NOT leave any messages for me, either by telephone or email, EXCEPT for requests for me to contact this office.*

_____ *(Please Initial)* *I authorize practice physicians to contact me by EMAIL to address listed above.*

_____ *(Please Initial)* *I authorize physicians or staff to call and leave voicemail messages for me at the telephone numbers listed above.*

**Your trust is important to us. As a measure to assure confidentiality of your personal health information, any necessary email communication with patients will be sent by one of our doctors. The policies of this practice prohibit staff members from sending any direct email to patients, including forms, physician orders, test results, and work/school releases. Thank you for your understanding.*

>>ONE MORE PAGE TO GO -- ADDITIONAL INFORMATION NEEDED<<

The HomeTown Doctors, PA

Patient's Legal Name _____

What is your **Preferred Pharmacy** AND location: _____

Emergency Contact Name: _____

Relationship: ___ Spouse ___ Partner / Significant Other ___ Child ___ Sibling

___ Other (*please specify*): _____

Emergency Contact Phone Number: _____

Who may we thank for referring you to our office? _____
(Person's Name)

If not referred by someone else, how did you learn about our medical practice?

____ Google/Internet Search ____ I got something in the mail
____ Facebook Page ____ *Salisbury Post* Newspaper
____ Concord-Kannapolis *Independent Tribune* Newspaper
____ I got an email

Person Responsible for Payment_____

Payment Today: Cash_____ Check_____ Credit (or) Debit Card_____

I understand The Hometown Doctors, P.A., provides primary care by direct payment-for-services. I am aware that such membership is <u>not</u> required to become a patient of this practice or to receive treatment from our physicians.

Patient/Guardian Signature: _____ Date: _____

Our physicians and staff are eager to share with you the benefits available to the patient-members of our **Practice Membership Plans** for affordable direct payment.

OFFICE STAFF USE ONLY (Membership Information _____ TS _____ PJ _____ STAFF _____ Written)
Monthly _____ Annual _____ Date of first ACH _____

(HTD Last Update: 03/10/2020)

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