245 Le Phillip Court NE 2nd Floor, Suite B Concord, NC 28025 704.256.8300

New Patient Registration

Patient's Legal Name _____

Sex: _____ Date of Birth: _____ Patient Marital Status: _____

If Patient is a Minor, name of Legal Guardian: _____

Home Address: _____

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

Email Address: _____

Who is Legally Authorized to make Patient's healthcare decisions?

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

Please read and initial 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 using the following methods:

_____ (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 using the EMAIL address listed above.

_____ (Please Initial) I authorize Physicians or Staff to call and leave VOICEMAIL messages for me at the telephone numbers listed above.

Preferred Pharmacy and Location: _____

How did you learn about our office? _____

Person Financially Responsible for Payment: _____

Phone Number: (_____) _____- _____

Patient/Guardian Signature: _____ **Date:** _____

Printed Name: _____