

**Nancy's Prevention Clinic
Patient Registration**

Name of Patient _____ Sex _____
Last, First MI

Soc. Sec. No: _____ Date of Birth: _____ Age: _____

Driver's License No: _____ Marital Status: Married Single Widowed Divorced

Mailing Address _____
Number and Street, City, State and Zip Code

Residence Address _____
Number and Street, City, State and Zip Code

Home phone: () _____ Work phone: () _____ Cell phone: () _____

Employer: _____ Full Time Student? Y/N
Name and Address

Emergency Contact: _____ Relation to Patient: _____
Name and Phone No.

SPOUSE: Name _____ Date of Birth: _____

Employer: _____
Name and Address Phone

Primary Care Physician: _____ Referred by Dr. _____
RESPONSIBLE PARTY

Name of Guarantor: _____
Last, First MI

Address: _____
Number and Street, City, State and Zip Code

Home phone: () _____ Work phone: () _____ Cell phone: () _____

Soc. Sec. No: _____ DOB: _____ Relation to Patient: _____

Employer: _____
Name and Address

Notice to Medi-Cal-eligible Patients

This physician practice does not accept Medi-Cal is a **primary or secondary** insurance.
I have been informed that Medi-Cal will not be accepted for any past, present or future appointments.

Signature: _____ Date: _____

Assignment/Consent

I hereby give consent for medical or surgical treatment to the medical provider to care for myself, or I am duly authorized by the patient as his/her general agent to give consent for such treatment. I hereby give consent to release of medical information to consulting physicians and other medical personnel as may be required in the rendering of treatment. I understand that I am financially responsible to the above office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred.

Signature: _____ Date: _____

Printed Name: _____ Relation to Patient: _____

Nancy's Prevention Clinic
1279 E. First Ave. Suite C, Chico, CA. 95926
Telephone: 530.342.6262/Fax: 530.342.6234

CONSENT TO RELEASE CONFIDENTIAL INFORMATION FOR MEDICAL PURPOSES

I, _____ Date of Birth _____

Patient first and last name

Hereby authorize the exchange of my confidential information and/or medical records between Nancy's Prevention Clinic and:

_____ Phone: _____

_____ Fax: _____

_____ Phone: _____

_____ Fax: _____

This request for information pertaining to medical history, mental or physical condition, services rendered, diagnosis, or treatment complies with Confidentiality of Medical Information Act of 1991, Section 56, etc. California Civil Code, and section 199.2 (G) Health and Safety Code.

This additional information will not be released unless INITIALED

Additional authorization for:

_____ Drug/Alcohol Condition _____ Mental Health Condition _____ HIV results

I acknowledge that the data to be released may include material that is protected under federal law and that is applicable to any or all of the above. My signature authorizes release of information that I have initialed above.

This authorization shall remain in effect for one year from the date of signature. A copy of this authorization will be furnished to the patient upon request.

Signature of patient (parent/legal guardian, if minor) Date

Printed Name First, MI, Last

Witness Date