



## Patient Registration Form

**NAME:** \_\_\_\_\_

Last First M.I.

**EMAIL:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_/\_\_\_/\_\_\_

**SEX:**  Male  Female  Other **RACE/ETHNIC:**  White  African-Amer.  Asian  Hispanic/Latino  Other

**ADDRESS:** \_\_\_\_\_

Street, Apt., City, State, Zip

**PHONE:** HOME: \_\_\_\_\_ CELL: \_\_\_\_\_ OFFICE: \_\_\_\_\_

Ok To leave Message; If so which number \_\_\_\_\_

**INSURANCE:** \_\_\_\_\_

Company, Member ID, Name of Primary Insurance Holder, Contact number

### Responsible Party (Please Fill Out If Different Then Patient)

**NAME:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_/\_\_\_/\_\_\_

Last First M.I.

**Relation to Patient:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

Street, Apt., City, State, Zip

**PHONE:** HOME: \_\_\_\_\_ CELL: \_\_\_\_\_ OFFICE: \_\_\_\_\_

Ok To leave Message; If so which number \_\_\_\_\_

**EMERGENCY CONTACT** \_\_\_\_\_

Name Relationship Phone

**PHARMACY NAME (Address):** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ALLERGIES to Foods or Medicines:** \_\_\_\_\_

**REASON FOR VISIT:** \_\_\_\_\_

**HOW DID YOU LEARN ABOUT Katy Fulshear Internal Medicine: (CHECK ALL THAT APPLY)?**

- I have been here before  Referred by my doctor/clinic (name, phone) \_\_\_\_\_
- Web search  Referred by my school/employer (name) \_\_\_\_\_
- Ad  Referred by my friend/family/other (name) \_\_\_\_\_

**Consent for Medical Care, Record Keeping, Privacy Notice, and Payment Responsibility**

(1) I, as the client/patient, agree to receive care from a health care provider at Medicus Internal Medicine & Primary Care PLLC dba Katy Fulshear Internal Medicine. I give consent for examination, immunization, blood or skin testing, medical advice, prescribing medications if needed and other services from my provider.

(2) I understand that it is my responsibility to pay for services received. I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Medicus Internal Medicine & Primary Care PLLC dba Katy Fulshear Internal Medicine, Sarwat Makkani, DO all insurance benefits if any, otherwise payable to me for services rendered. I understand I am fully responsible for all charges whether paid or not by the insurance company. I hereby authorize Medicus Internal Medicine & Primary Care PLLC dba Katy Fulshear Internal Medicine to release all information necessary to secure the payment of benefits. I authorized the use of this signature on all insurance submissions.

(3) I authorize Medicus Internal Medicine & Primary Care PLLC dba Katy Fulshear Internal Medicine, Sarwat Makkani, DO to review outside pharmacy and medical records as applicable and as pertains to my medical care.

(4) I acknowledge that I have had the opportunity to read or receive a copy of the "Notice of Privacy Practices".

(5) Medicus Internal Medicine & Primary Care PLLC dba Katy Fulshear Internal Medicine will keep this record in the patient's medical file.

(6) By signing the form below, you hereby freely and voluntarily give your permission and are requesting that the vaccine(s) and/or test(s) be given to you or the person named below for whom you are authorized to make this request.

(7) I understand the risks and benefits of the test/vaccine being given to me and have the opportunity to read The Vaccine Information Sheet "VIS" on each vaccine, or a "Subject Information" pamphlet on each test, as stated by law, for me to read BEFORE I receive your shots and/or test(s). Your signature below indicates that you have read or have had the information explained to you and that you understand the benefits and risks of each vaccine administered. You hereby release and agree to hold harmless Medicus Internal Medicine & Primary Care PLLC dba Katy Fulshear Internal Medicine, its Officers, and Employees for any and all liability, of any kind or nature whatsoever, which might arise out of or result from any vaccine(s) and/or test(s) administered to you or your dependent.

**Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If Patient is not able to sign:**

**Print name of Care Giver:** \_\_\_\_\_