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________________

☐ By checking this box, I agree to receive SMS messages about communications from Katy Fulshear Internal Medicine. The SMS frequency may vary. Data rates may apply. Text HELP for assistance. Reply STOP to opt out of receiving SMS messages

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: ____