PATIENT REGISTRATION

FIRST NAME _____ LAST NAME _____

MIDDLE NAME _____ NICKNAME _____ SEX: FEMALE MALE

DATE OF BIRTH _____ PREFERRED LANGUAGE**_____

We are required by law to ask for your information concerning race, ethnicity and primary language. If you choose not To give us this information, we will mark your response as "declined". Required for Meaningful Use legislation, mandated by Congress.

RACE:** _____AMER INDIAN _____ ASIAN _____BLACK/AFRICAN AMER

_____NATIVE HAWAIIAN/PACIFIC ISLANDER _____ WHITE/CAUCASIAN _____OTHER _____ DECLINED

Ethnicity:** _____Latino _____Hispanic _____Other _____Declined SS# _____

HOME PHONE# _____ CELL PHONE# _____

WORK PHONE# _____ EMAIL ADDRESS* _____

Want access to online portal? YES NO IF YES EMAIL IS REQUIRED*

PLEASE BE ASSURED THAT YOUR EMAIL ADDRESS AND OTHER INFORMATION WILL NOT BE USED FOR ADVERTISING PURPOSES AND WILL BE KEPT CONFIDENTIAL ACCORDING TO HIPPA PRIVACY LAWS.

STREET ADDRESS _____

ZIP CODE _____ STATE _____ CITY _____

EMERGENCY CONTACT NAME _____ PHONE# _____

EMERGENCY CONTACT RELATION _____ WHO REFERRED YOU? _____

WHERE DID YOU FIND US? _____GOOGLE _____FACEBOOK _____INSURANCE CO WEBSITE _____OTHER

PREFERRED PHARM/LOC: _____

PRIMARY INS CO _____ ID# _____

GROUP # _____ IS SUBSCRIBER SAME AS PATIENT? Yes No

IF NO, SUBSCRIBERS NAME:_____ DATE OF BIRTH:_____

SUBSCRIBERS RELATIONSHIP TO PATIENT: _____PATIENT IS A STUDENT? Yes No

SECONDARY INS CO _____ ID# _____

GROUP # _____ IS SUBSCRIBER SAME AS PATIENT? Yes No

IF NO, SUBSCRIBERS NAME:_____ DATE OF BIRTH:_____

SUBSCRIBERS RELATIONSHIP TO PATIENT: _____

PATIENT AUTHORIZATIONS

I, _____ voluntarily request Michael W. Jones, MD
PRINT FIRST & LAST NAME
and/or such associates to treat my condition(s) as deemed necessary. This may include screening for substance abuse and/or HIV testing.

Signature of Patient Date

Permission to Discuss with Family and/or Friends

The Federal government now restricts Michael W. Jones, MD and Associate(s) of New Life Women's Health and Infertility of North Texas from discussing your health information and condition with other family members or person unless you specifically give your written permission.

By signing below, I grant Michael W. Jones, MD and Associate(s) of New Life Women's Health and Infertility of North Texas permission to discuss my protected medical information with the following individual(s) listed:

First/Last Name Relationship

First/Last Name Relationship

First/Last Name Relationship

Signature of Patient Date

New Life Women's Health & Infertility of North Texas
5801 W Virginia Pkwy #101B – McKinney, TX 75071
Office 469-352-7140 – Fax 214-973-5205