

WELCOME TO PromptMD!



REGISTRATION FORM

TODAY'S DATE: _____

(Please Print)

PATIENT INFORMATION

<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Last Name:	First Name:	Middle Initial:		
<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.					
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Date of Birth: ____/____/____	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number: ____-____-____
Mailing Address:		Apartment #	City:	State:	Zip:
Home Phone Number: (____)____-____	Mobile Phone Number: (____)____-____	Confidential E-Mail Address:			
Employer:			Occupation/Title:		

EMERGENCY CONTACT

Name of Contact:	Relationship to Patient:	Phone: (____)____-____
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BEST FORM OF CONTACT

Best Form of Contact: Choose one <input type="checkbox"/> Home Phone <input type="checkbox"/> Mobile Phone	Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	Best time to call?	If unable to reach you, do you authorize release of Your medical information to the following contact? If, yes, name?
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SURVEY (OPTIONAL)

How did you hear about and why did you choose PromptMD? (check all applicable)

Close to Home/Work Walked by Google Facebook Yelp Friend/Family Great Reviews
 Other Website/Internet Weekend Hours ZocDoc Signage / Ad The Digest Magazine/Email Ad

To better our service, we've placed you on our friendly SMS survey (SMS and data rates may apply) opt-out

REASON FOR TODAY'S VISIT

MUST FILL OUT!

Symptoms & How Long?	PHARMACY USED: ADDRESS/ZIPCODE:
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FOR MINOR PATIENTS: PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:	Date of Birth:
Social Security Number:	Phone Number:

FINANCIAL POLICY (We accept credit or debit cards, cash. Personal checks are not accepted.)

Payment for today's visit is expected at time of service. Prompt MD's office visits start at \$110 and are based on level of service. Any laboratory procedures, diagnostic and medical/surgical are additional to office visit fees. For insurances that PromptMD is non-participating, you will be given a paid receipt and claim form for you to submit to your carrier for possible reimbursement according to your health insurance policy. Please indicate method of payment for today's visit: Cash Credit Card Medicare Insurance

Signature _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I (name of patient) X _____ acknowledge and agree that I have been given the opportunity to review a copy of PromptMD's Notice of Privacy Practices.