NORTHWEST MEDICAL GROUP PATIENT REGISTRATION FORM

Today's Date:			
Primary Care Provider:		Referring Provider:	
PATIENT DEMOGRAPHICS			
Last Name:	First name:	Middle Initial:	Sex:
Date of Birth:	Age:	Social Security Number:	
Address:			
City:		State:	Zip:
Home Phone:	Cell Phone:		Marital Status:
IF THE PATIENT IS NOT THE GUARANTOR, PLEASE COMPLETE:			
Guarantor Name:		Guarantor Date of Birth:	
Guarantor Social Security Number:		Relationship to Patient:	
Guarantor Address:			
City:		State:	Zip:
Home Phone:		Cell Phone:	
EMERGENCY CONTACT			
Emergency Contact Name:		Relationship to Patient:	
Home Phone:		Cell Phone:	

CONFIDENTIALITY

Due to the importance of protecting the confidentiality of the patient's medical information, we will not verbally disclose any medical information to the patient's family, friends, significant others, or any other individual unless the patient has authorized the release of medical information by specifying in writing the list of people who may obtain such medical or private information. (A signed release will still be needed for printed records.)

Name:	Relationship:	Phone Number:	Leave Messages & Speak with (Y or N):	Review Your Account (Y or N):	Pick Up Prescriptions, Orders, & Medical Records (Y or N):
1.					
2.					

PATIENT PORTAL

I consent to participate in the PATIENT PORTAL and understand that my personal health and individually identifying information is made available to me and or my designee in the web-based portal application. I understand that I am responsible for safeguarding my access information, and should I choose to provide access to an Authorized Representative, they would have the same ability to perform all the same functions I am able to perform. YES NO

Email:

PREFERENCES		
Would you like us to report any immunzations you receive to the national database?	YES	NO
Do you consent to have your medications retrieved electronically from your pharmacy?	YES	NO
What is your preferred pharmacy?		

SIGNATURE		
I hereby confirm that the above information is accurate and true:		
Patient/Guardian Signature:	Date:	
Printed Name:	Relationship to Patient:	