GENESIS REGENERATIVE MEDICINE

PATIENT REGISTRATION FORM

Full Name: SSN:

Gender: M ☐ F ☐ DOB: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: Apt No.:

City: State: Zip Code:

Home Phone: Mobile Phone: Consent to text: ☐ Yes ☐ No

Work Phone: Email:

Preferred method of contact: ☐ Home Phone ☐ Mobile ☐ Work

Language: Race: ☐ or decline Ethnicity: ☐ or decline

Emergency Contact/Phone#: Relationship:

Primary Care Physician: Phone:

*The services provided by Genesis Regenerative Medicine are **CASH ONLY**. Please refer to the Patient Financial policy for details.*

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at (253) 874-8774 to obtain a current copy.

I acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices.

Patient Signature

Date

Print Name

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