

## TRINITY URGENT CARE AND OCCUPATIONAL HEALTH 10200 TRINITY PARKWAY, SUITE 204

## **REGISTRATION FORM FOR QUICK VISITS, EXAMS, AND PROCEDURES**

	NAME: LAST		FIRST			MI	ALIA	LIASES or MAIDEN NAME				
	DOB SOCIAL SECURITY No.			TY No.	EMPLOYER or			COMPANY NAME				
PATIENT												
ATI	ADDRESS		•	CITY		•		STATE		ZIP		
Ь												
	HOME PHONE No.			CELL PHONE No.				GENDER			○ FEMALE	
									SINGLE	○ MAR	RIED	
		IVELY PROVIDE CARE, FICE FOR: <b>TREATMEN</b>										
	OR DANGER TO HAVE THE FOLLO	<b>OOTHERS.</b> OWING RIGHTS AND F	RESPONSIBLITIES: <b>CC</b>	PIES OF RECORDS	, RELEASE OF RECO	ORDS, RES	STRICTIO	N ON RECO	ORDS, CONTA	ACT, AMENDMI	ENTS,	
ACC	OUNTING FOR D	ISCLOSURES, QUESTI	ONS, COMPLAINTS,	AND CHANGES.								
IF YC	OU WOULD LIKE	TO READ THE PRIVAC	Y POLICY IN ENTIRET	Y, ASK ONE OF TH	E RECEPTIONISTS.							
I ACI	(NOWLEDGE THA	AT I HAVE RECEIVED A	AND READ THE ALSH	IFA MEDICAL GRO	UP'S PRIVACY NOTI	CE						
PATI	ENT SIGNATURE			DATE								
		DI EACE DETI	E CHEET OF	DADED WITL	L VOLIB BHOTO IDENTIFICATION							
	PLEASE RETURN THIS HALF SHEET OF PAPER WITH YOUR PHOTO IDENTIFICATION											
		TRINITY URGENT CARE AND OCCUPATIONAL HEALTH										
	10200 TRINITY PARKWA											
	REGISTRATION FORM FOR QUICK VISITS, EXAMS,						PROCE	DURES				
	NAME: LAST FIRS		FIRST	Т		MI	ALIA	SES or MAIDEN NAME				
		January										
Þ	DOB	SOCIAL SECURITY No.				EMPLOYER or COMPANY NAME						
PATIENT	ADDRESS			СІТУ		<u>I</u>		STATE		ZIP		
PA	ABBILESS							317112				
	HOME PHONE No.			CELL PHONE No.				GENDER	MALE	☐ FEMA	ALE	
									SINGLE	○ MAR	RIED	
IN O	RDER TO EFFECT	IVELY PROVIDE CARE,	THERE ARE TIMES \	VHEN WE WILL NE	ED TO SHARE YOU	R PERSON	IAL HEAL	TH INFORM	1ATION WITH	I OTHERS BEYO	ND THE	
		TICE FOR: TREATMEN										

YOU HAVE THE FOLLOWING RIGHTS AND RESPONSIBLITIES: COPIES OF RECORDS, RELEASE OF RECORDS, RESTRICTION ON RECORDS, CONTACT, AMENDMENTS, ACCOUNTING FOR DISCLOSURES, QUESTIONS, COMPLAINTS, AND CHANGES.

IF YOU WOULD LIKE TO READ THE PRIVACY POLICY IN ENTIRETY, ASK ONE OF THE RECEPTIONISTS.

I ACKNOWLEDGE THAT I HAVE RECEIVED AND READ THE ALSHIFA MEDICAL GROUP'S PRIVACY NOTICE

PATIENT SIGNATURE DATE