THE HOMETOWN DOCTORS, P.A.
DIRECT PRIMARY CARE
EST 2018

1925 Concord Lake Road Kannapolis, NC 28083-6448 704.256.8300

New Patient Registration

Patient's Legal Name _____

Sex: _____ Date of Birth: _____ Patient Marital Status: _____

If Patient is a Minor, name of Legal Guardian: _____

Home Address incl City/State/Zip code: _____

Cell Phone Number (_____) _____- _____ **Home Phone Number** (_____) _____- _____

Email Address: _____

Who is Legally Authorized to make Patient's healthcare decisions?

_____ Self/Patient _____ Parent/Legal Guardian/Parent _____ Healthcare Representative (POA)

Please read and give your consent to your preferred method(s) of contact.

If Physicians and Staff from The Hometown Doctors need to contact me by email, telephone or text, I am aware and understand they may need to share my Personal Health information in their communication. I hereby authorize the Physicians and Staff to contact and leave messages using the following methods:

I authorize practice Physicians and Staff to contact me using:

- ☐ EMAIL
- ☐ TELEPHONE/VOICEMAIL
- ☐ TEXT
- ☐ DO NOT leave any messages for me, by email/voicemail/text, EXCEPT for requests for me to contact this office.

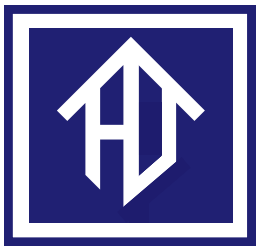
Preferred Pharmacy and Location: _____
How did you learn about our office? _____

Person Financially Responsible for Payment: _____

Phone Number: (_____) _____- _____

Patient/Guardian Signature: _____ **Date:** _____

Printed Name: _____



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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____Date of Birth: _____

Emergency Contact: Will be used only if we are unable to reach you.

Name: _____Phone Number: _____
Relationship: ___ Spouse ___ Partner / Significant Other ___ Child ___ Sibling
___ Other (*please specify*): _____

I hereby authorize THE HOMETOWN DOCTORS, PA, to disclose specific health information from the records of the above-named Patient to the Individuals listed below. Your options are to (a) designate one person, (b) two persons, or (c) no one.

☐ I understand that I have chosen not to Authorize the disclosure of my Health Information to any individual.

Name	Telephone Number	Relationship to Patient

I understand that this Authorization is valid until revoked by me.
I understand that I may revoke this Authorization in writing or via email at any time.
I understand that any action taken on this Authorization prior to the rescinded date is legal.
I understand that my information may not be protected from re-disclosure by the requester of the information.
I understand that if my record contains information relating to HIV infection, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information.
I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment.

I understand that I may request a copy of this signed Authorization.

_____ _____
Signature Date