McMinn Clinic

World class wellness medicine in Birmingham

PATIENT REGISTRATION

Name: ______________________ Today's Date: ______________

Address: ____

City: __________ State: __________ Zip: __________ E-mail: __________

Date of Birth: ______________ Social Security Number: ______________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Occupation: ______________ Place of Employment: ______________

Name of Policy Holder: ________________________________

Date of Birth of Policy Holder: ______________ Circle Status: Married Single

Place of Employment of Policy Holder: ______________________

Emergency contact: ______________________ Phone: ______________

Other medical providers: ________________________________

Name of Pharmacy: ______________________ Phone: ______________

Reason for Visit: ____

Allergies: ____

How did you learn about The McMinn Clinic? ______________________

Acknowledgment of receipt of Privacy Practices for Total Wellness MD:

The staff of Total Wellness MD is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information (PHI) and your privacy rights. The delivery of your healthcare service will in no way be conditioned upon your signed acknowledgment. If you decline to provide the signed acknowledgment, we will continue to provide your treatment, and will use and disclose your PHI for treatment, payment, and health care operations when necessary. I acknowledge that I have received the Notice of Privacy Practices for Total Wellness MD.

Name of patient (PLEASE PRINT): ______________________________

______________________________________ ______________

Signature of patient or authorized representative Date