TRINITY URGENT CARE AND OCCUPATIONAL HEALTH

10200 TRINITY PARKWAY, SUITE 204

REGISTRATION FORM FOR QUICK VISITS, EXAMS, AND PROCEDURES

PATIENT

NAME: LAST	FIRST	MI	ALIASES or MAIDEN NAME
DOB	SOCIAL SECURITY No.	EMPLOYER or COMPANY NAME	
ADDRESS	CITY	STATE	ZIP
HOME PHONE No.	CELL PHONE No.	GENDER ◯ MALE ◯ FEMALE	◯ SINGLE ◯ MARRIED

IN ORDER TO EFFECTIVELY PROVIDE CARE, THERE ARE TIMES WHEN WE WILL NEED TO SHARE YOUR PERSONAL HEALTH INFORMATION WITH OTHERS BEYOND THE URGENT CARE PRACTICE FOR: **TREATMENT, PAYMENT, OPERATIONS, EMERGENCIES, AS REQUIRED BY LAW, GOVERNMENTAL REQUIREMENTS, CRIMINAL ACTIVITY, AND/OR DANGER TO OTHERS.**

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

PATIENT SIGNATURE	DATE

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