Your Hospital's Logo Here

OUTPATIENT REGISTRATION

DATE:	TIME IN: (Military Time)	MODE OF ARRIVAL:
REG. CL:	MED. REC. NO:	PATIENT NO:

PATIENT

PATIENT NAME:			SSN:		DOB:
HOME PHONE:	WORK PHONE:	SEX:	RACE:	MARITAL STATUS:	RELIGION:
EMPLOYER:	EMPLOYER'S ADDRESS:	(City)	(State)	(Zip)	

GUARANTOR

NAME:	PAT. REL TO GUARDIAN:	HOME PHONE:	WORK PHONE:
ADDRESS:	(City)	(State)	(Zip)
GUARANTOR'S EMPLOYER:	(City)	(State)	(Zip)

INSUR

PRIMARY INSURANCE CARRIER:	POLICY NO:	SUBSCRIBER:
SECONDARY INSURANCE CARRIER:	POLICY NO:	SUBSCRIBER:

VISIT

NATURE OF VISIT:	DATE / TIME OF ACCIDENT or ILLNESS:	PLACE OF ACCIDENT:	WORKER'S COMP:
REFERRING PHYSICIAN:	EMERGENCY NOTIFICATION:		PHONE:
COMPLAINT:	SERVICES: ☐ LAB ☐ PHYSICAL THERAPY ☐ X-RAY ☐ OTHER ☐ EKG		IN - OUT SURGERY: ☐ LOCAL ☐ GENERAL

DIAGNOSIS: ICD9:

PROCEDURE: CPT:

PHYSICIAN'S NOTES / ORDERS	NURSE'S NOTES

MD SIGNATURE:	DATE:	TIME: (Military Time)

MEDICAL RECORDS COPY

CONSENT TO OPERATION, ANESTHETICS AND OTHER MEDICAL SERVICES

1. I authorize the performance upon _____ of the following operation or procedure, _____ to be performed under the direction of Doctor _____.
2. I consent to the performance of operations and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor or his associates or his assistants may consider necessary or advisable in the course of the operation.
3. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service, with the exception of _____.
4. The nature and purpose of the operation, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me by the responsible physician. No guarantee or assurance has been given by anyone as to the results that may be obtained.
5. I consent to the photographing or televisioning of the operation or procedure to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided that my identity is not revealed by the pictures or by the descriptive texts accompanying them.
6. For the purpose of advancing medical education, I consent to the admittance of observers to the operating room.
7. I consent to the disposal by hospital authorities of any Tissue or Parts which may be removed.

CROSS OUT ANY PARAGRAPHS ABOVE WHICH DO NOT APPLY

SIGNED:	DATE:	TIME: (Military Time)
WITNESS:	If other than patient signed, STATE RELATIONSHIP:	

ADVISEMENTS

1. I (We) hereby affirm that _____ has had nothing to eat or drink (including water) since 12:00 midnight on (Day) _____ (Date) _____.
2. My transportation from the Hospital has been arranged and upon discharge I will be accompanied by a competent adult to my home
3. In my best interest, for the next twenty-four (24) hours, I have been advised of the following:
   a - The extent of activity allowed
   b - The avoidance of performing skillful or dangerous work activities
   c - Not to sign legal papers
   d - The avoidance of alcoholic beverages
   e - The avoidance of tranquilizers, sedatives or any other drugs unless specifically ordered by my physician.

SIGNED:	DATE:	WITNESS:

In case of minor or person otherwise unable to sign

SIGNED:	DATE:	WITNESS:

CONSENT FOR SERVICE AND RELEASE OF HOSPITAL RECORDS

I hereby authorize Your Hospital to furnish and administer to me such diagnostic procedures, treatment and medications as may be deemed advisable IN the course of my reception of service.

The Hospital records concerning the patient are the property of XXXXX HOSPITAL and are maintained for the benefit of the patient, the medical staff and the Hospital. I hereby authorize XXXXXX HOSPITAL to release these records to the patient's personal physician and to any other individual and private or governmental agency responsible for payment of the patient's care and treatment.

SIGNED:	DATE:	WITNESS:

In case of minor or person otherwise unable to sign

In behalf of _____. I make the aforementioned request and authorize the Hospital on his / her behalf.

SIGNED:	DATE:	WITNESS: