New Patient Registration Form

ST. JOSEPH PRIMARY CARE
a ministry of caring

4400 Falls of Neuse Rd., Suite 101, Raleigh, NC 27609 | 4057 US-70 Bus. W., Clayton, NC 27520

Patient Information

Patient Information		
Last Name:	First Name:	
Mailing Address: Apt#		City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:
Preferred Method of Contact for reminder calls (Please select only one option) ☐Voice ☐Text ☐Email		
Please select preferred number: ☐ Home ☐ Cell ☐ Work		Email:
Date of Birth:	Sex: ☐Male ☐Female	Family Physician or Pediatrician:
Marital Status: ☐ Decline ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed		
Employer Name:		Emergency Contact Name:
Emergency Contact Phone:		Relationship to Patient:

Additional Information

Additional Information	
How did you hear about us?	
Race: ☐ Decline ☐ Hispanic ☐ American Indian ☐ White ☐ Asian ☐ Black or African American ☐ Pacific Islander	Ethnicity: ☐ Decline ☐ Hispanic/Latino ☐ Non-Hispanic
Can we leave a message regarding your medical care & test results? ☐ Yes ☐ No	
Preferred Pharmacy Name & Location:	

Payment (MCP)

Membership Care Program (MCP) & Payment	
I am joining the Membership (MCP) today ☐ Yes ☐ No (fee will be charged as a non-member) Pay the membership fee in full today ☐ Yes ☐ No Pay the membership fee in 30 days ☐ Yes ☐ No *Pay the membership fee in 90 days ☐ Yes ☐ No	Membership Fee to join the MCP ☐$1,000 (age 7 +, per year, per member) ☐ Other_____ _____ *Please review and sign the **Terms and Conditions** agreement to join the Membership Care Program.

Insurance

Insurance Information
Do you have health insurance? ☐ Yes ☐ No If yes, we will need a copy of your health insurance card. Note: St. Joseph Primary Care is an out-of-network provider. We'll NOT bill your health insurance. We'll provide your health insurance to a third party, i.e. labs, medications, x-ray, and other specialist cares. It's your financial responsibility to pay for these services that provided by a third party (outside of St. Joseph Primary Care).

CONSENT TO MEDICAL CARE AND TREATMENT

I am being treated at St. Joseph Primary Care ("STJPC"), and I consent to all medical and surgical care, examinations and tests determined by STJPC to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I assume full risk and responsibility and release STJPC and any individual provider from responsibility for things that might go wrong if I do not receive the medical care and treatment recommended to me. I understand that if an employee, physician, or affiliate of STJPC becomes contaminated with my blood or body fluids through any type of exposure, that I may be tested for the Hepatitis Virus and/or the Human Immunodeficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS). I fully understand this agreement, and consent will continue until cancelled by me in writing.

Patient Name _____Date:_____

Signature _____Date:_____

I have reviewed a copy of St. Joseph Primary Care's Privacy Notice. _____initials