Immigration Registration (PLEASE PRINT CLEARLY)

MyMedicalClinic
High-quality healthcare, from our doctors to you

Today's Date: _____ Date of Birth: _____

SS # _____ - _____ - _____ Alien Registration #: A - | | | | | | | | | |

Patient's Name: _____ SS # _____ - _____ - _____
First Name MI Last Name

❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Street Address: _____

City / State / Zip Code: _____

Home Phone (_____) _____ Cell Phone (_____) _____

Birth Place (City/Town/Village/Country): _____

PRESENT PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED NFORMATION AND ANY VACCINATIONS RECORDS

- I can read and understand English.
- I agree to pay all costs that may incurred today.

_____ _____
Patient Signature (if patient is a Minor, must have Responsible Party Signature) Date

I authorize Dr. C.ANAND – CIVIL SURGEON to treat me and use my personal health information for healthcare immigration operations.

_____ _____
Patient Signature (if patient is a Minor, must have Responsible Party Signature) Date

Consent for Testing, Vaccinations, and Blood Draw:

____Skin TB Testing ____ Vaccination as needed ____Blood Draw

I acknowledge the potential risks and benefits of testing/vaccination. The possible complications of such tests/vaccinations have been explained to me as well as the possible risks and benefits of not obtaining these procedures

_____ _____
Patient Signature (if patient is a Minor, must have Responsible Party Signature) Date

I acknowledge I have been provided with a copy of Privacy Practices from My Medical Clinic

_____ _____
Patient Signature (if patient is a Minor, must have Responsible Party Signature) Date

Update: 07/14/2015 - MML