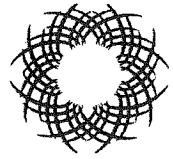


Immigration Registration (PLEASE PRINT CLEARLY)



MyMedicalClinic
High quality healthcare, from our doctors to you

Today's Date: _____ Date of Birth: _____

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

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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 INFORMATION 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