Optimal Health Medical Clinic
855 E Brown Rd Ste 10, Mesa, AZ 85203
Phone (623) -920-3171 FAX:949-655-2753

REGISTRATION FORM

Today's date:	Referred By:

PATIENT INFORMATION

Patient's last name:	First:	Middle:			

Is this patient's legal name? ❑ Yes ❑ No	If not, what is the legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Primary phone no: ( )	Other phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Parent/Guardian email address:	

INSURANCE INFORMATION

(Please give your insurance card(s) and ID to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Primary phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's id. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Legal Guardian	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Legal Guardian	❑ Other

AUTHORIZED INDIVIDUALS TO WHOM MEDICAL INFORMATION MAY BE RELEASED

Name:	Relationship to patient:	Birth date:	Primary phone no.: ( )
Name:	Relationship to patient:	Birth date:	Primary phone no.: ( )

PHARMACY INFORMATION

Pharmacy: Address:

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IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Primary phone no.: ( )	Other phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Fatima Health LLC d/b/a Optimal Health Medical Clinic. I understand that I am financially responsible for any balance. I also authorize Fatima Health LLC d/b/a Optimal Health Medical Clinic or my insurance company to release any information required to process my claims.

Parent/Guardian signature *Date*

AUTHORIZATION TO VIEW AND OBTAIN EXTERNAL PRISCRIPTION HISTORY

I authorize the medical providers of Fatima Health LLC d/b/a Optimal Health Medical Clinic to view and obtain my external prescription history via electronic prescription services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff through these services, and may include prescriptions back in time for several years.

Parent/Guardian signature *Date*

NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Fatima Health LLC. The Notice of Privacy Practices also describes my rights and Fatima Health LLC duties with respect to my protected health information. The Notice of Privacy Practices can also be found on the website at optimalfatimahealth.com

Fatima Health LLC, d/b/a Optimal Health Medical Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the practice website.

Parent/Guardian signature *Date*