Patient Registration & Consent to Treatment

To be completed by a parent or legal guardian if the patient is under 18 years of age

Please circle all that apply

Town Family Doctor
Vedad Seremet MD

Last Name			**Address**		
First Name	**MI**				
Previous Name			**City** Louisville Prospect		
DOB			**State** KY **Zip**		
SS #			**Sex**	Female Male	Transgender
Home Phone			**Marital Status**	Married Single	Separated Divorced
Cell Phone				Partner Widowed	Unknown
Work Phone	**Extension**		**Your E-mail:**		
Is it OK to leave a message on an answering machine? Yes No			**Other person authorized to discuss your medical conditions with us**		
Which Phone Home Cell Work			Nobody		

Person Responsible for Bill (If different from insured)				
Last Name				
First Name	**MI**			
DOB				
SS #				
Address same as patient address				
City Louisville Prospect				
State KY **Zip**				
Relationship				
Custodian Guardian (If patient is minor, provide a copy of custodial papers)				

Pharmacy	Walgreens	Kroger	Rite Aid	Target
	Wal-Mart	Mail Order	Costco	Meijer
Address				
City Louisville				
State KY **Zip**				
Phone #				
Fax #				

Insurance	Humana	Anthem-BCBS	Aetna	United
	Cigna	Medicare	Other	

Employer Name			
Employer Address			
City Louisville			
State KY **Zip**			
Employee Status	Full time	Part time	Self employed
	Unemployed	Retired	
Student Status	Full time	Part time	Not student

Emergency Contact			
Last Name			
First Name			**MI**
Relationship			
Address Same as patient address			
City Louisville			
State KY **Zip**			
Cell Phone			
Home Phone			

Do you have an advance directive or living will? Yes No

1. I authorize the release of medical and pharmaceutical information necessary to process my medical claims. I authorize payment from my insurance company to be made directly to the facility.
2. I understand that I am responsible for and agree to pay any and all expenses not covered by my insurance or which are not paid by the insurance company at the time of visit if applicable or when I receive invoice.
3. I acknowledge I have been given a copy of and read the Town Family Doctor, PLLC Notice of Privacy Practices.
4. My signature also serves as consent for medical treatment.

Signature **Date**

Relationship	Self	Parent	Spouse, Partner, Legal Guardian
How did You hear about our office?	1.Dr. Seremet	3.My Insurance Company, web	5.Mail
	2.Family Member, Friend	4.Driving by neighborhood	6.Other

Thank You for choosing us as your Primary Care Provider