

Patient Registration & Consent to Treatment

Town Family Doctor

Vedad Seremet MD

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

Please circle all that apply

Last Name		Address			
First Name	MI				
Previous Name	City	State	Zip		
DOB	Race	Ethnicity	Language		
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)	

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	

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	

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