PATIENT REGISTRATION
Nicodemus M. Watts, MD

****************PLEASE COMPLETE ENTIRE FORM****************

Date: _____

Patient's Name (Last, First, MI) _____

Responsible Party's Name: _____

Address: _____

_____

Home Phone: ( )_____ Work Phone: ( )_____
Cell Phone: ( )_____

Responsible Party's Social Security # (SSN): _____

Relationship to Patient: _____

Patient Information: Sex ___ Date of Birth: _____ SSN: _____

Emergency Contact Information:

Primary Care Physician: _____ Phone: ( )_____

Address, if known: _____

Emergency Contact Person (if not Responsible Party): _____

Preferred Phone: ( )_____ Relationship to Patient: _____

AUTHORIZATION FOR TREATMENT & TERMS:

I hereby request and consent to evaluation and treatment of the above named as mutually agreed upon between me and physician. Service offered are voluntary and will be conducted in accordance with community standards of care. Services provided will be considered confidential unless release of information is requested by me for designated purposes in the best interest of the patient. I accept responsibility for payment of charges as discussed with the physician. Payment is due at the time of service delivery.

Printed Name: _____

Signed: _____ DATE:_____
Patient or Responsible Party, if patient is a minor

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