CertMedicals Walk-In Clinic
and Wound Care PLLC
917 Rinehart, Road, 2041
Lake Mary, Florida 32746

REGISTRATION FORM

Today's Date: [Date]	Current PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	
Date of Birth:	E-mail Address:	Phone Number:	

Pharmacy Name:	Pharmacy Phone:	Pharmacy City:	Birth date:	Age:	M ☐ F ☐ OTHER ☐

Emergency Contact:	Relationship:	Contact Phone Number:

HOME ADDRESS: [ADDRESS/ P.O BOX, CITY, ST ZIP CODE]

Street Address:	City:	State	Zip Code:
Occupation:	Employer:		Employer phone no.:

MEDICATIONS/ALLERGIES

☐ Copy of Medication List Provided ☐ Copy of Allergy List Provided

☐ No Medications ☐ No Allergies

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance:	Group ID:	Policy ID number:
Other Insurance:	Group ID:	Policy ID number:

ASSIGNMENT, PRIVACY, CONSENTS& RELEASE

ASSIGNMENT & RELEASE -The undersigned authorizes the release of any information relating to the claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for service rendered offer services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependent, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

To pay and hereby assign directly to CertMedicals Walk-In Clinic and Wound Care or its Subsidiary Corporation all benefits, if any, otherwise payable to me for the services as described on the attached forms. I understand that in the event my insurance denies the claim, then I am financially responsible for all charges incurred.

HIPPA PRIVACY POLICY -By signing this written acknowledgment. I hereby expressly acknowledge receipt of CertMedicals Walk-In Clinic and Wound Care'snotice of privacy practices.

CONSENT TO TEXT/VOICE MESSAGE -I hereby expressly consent to receive automated text and voice messages at the telephone number I provided.

LIABILITY RELEASE. It is your responsibility to go to participatingLaboratory/Diagnostic testing facilities that your insurance authorizes you to utilize. You are fully responsible for payment.

AUTHORIZATION TO RELEASE MEDICAL RECORDS - This consent also authorizes for the release of information regarding alcoholism and/or drug abuse, mental health/rehabilitation, HIV (AIDS) testing and/or testing for sexually transmitted diseases.

Print Name:	Patient Signature:	Date:

Parent/Guardian/Witness signature

Date