

CURRENT PATIENT INFORMATION

Last Name

First Name

Preferred Name

Middle Name

Date of Birth

Address

Address Line 2

City

State

Zip

Home Phone

Mobile Phone

Work Phone

Social Security #

Sex at Birth

Current

Language

Translation Required

Race

Ethnicity

Marital Status

Employer

Preferred Pharmacy

Special Communication Needs

Preferred Provider

- ☐ Jennalee Olsen
- ☐ Melissa Davis
- ☐ Kip Littau

GUARANTOR INFORMATION

Party responsible for payment on account

Name

Address

Address Line 2

Relationship to Patient

Date of Birth

Phone

Social Security #

ONLINE PORTAL REGISTRATION

- ☐ Yes - establish a portal account
- ☐ No - I do not want a portal account now

Email

EMERGENCY CONTACT

I approve the contact below to have access to my private medical information in its entirety, unless specified otherwise.

Name

Relationship

Phone

ADDITIONAL CONTACTS

I approve the contacts below to have access to my private medical information in its entirety, unless specified otherwise.

Name

Relationship

Phone

Name

Relationship

Phone



ACKNOWLEDGEMENT, AUTHORIZATION + CONSENT

Hometown Integrative Health | Registration Form

Patient Name

DOB

I have read the Acknowledgement and Consent Policy for Hometown Integrative Health (available on our website at www.hometownfamilyhealth.org or as a hard copy from staff). I request, agree to, and consent to the evaluation and treatment of myself and/or my child(ren)/dependent(s), including any studies or procedures deemed necessary or appropriate for diagnosis or treatment by Hometown Integrative Health staff. I understand that Hometown Integrative Health operates as a subsidiary of Hometown Family Health and may utilize shared resources including staff, website, facilities, utilities, and electronic medical records (EMR). I acknowledge that all services provided through Hometown Integrative Health are cash-based and are not submitted to insurance. I also acknowledge and consent to the use of AI scribe technology to assist in documentation and care.

Signature

Date

I have read and understand the HIPAA/Privacy Policy for Hometown Integrative Health (available on our website at www.hometownfamilyhealth.org or as a hard copy from staff).

Signature

Date

I have read and understand the Financial Policy for Hometown Integrative Health (available on our website at www.hometownfamilyhealth.org or as a hard copy from staff).

Signature

Date

I authorize Hometown Integrative Health to obtain and review my medication history from relevant sources for the purpose of providing safe and effective care.

Signature

Date

I authorize Hometown Integrative Health to contact me via phone call and/or text message at the number(s) I have provided, including for appointment reminders, care-related communication, and administrative purposes.

Signature

Date