Westchase Clinical Associate Registration Form

USCIS Patients

Patient Information (Please Sign and return to Receptionist**)** **MR #:** _____

Last Name		First Name		Middle Initial	Date of Birth
Address		City		State	Zip
Home Phone	Day Phone	Cell Phone	E-mail		
Preferred Language		Race		Ethnicity	
Gender: ❑ Male ❑ Female					
Driving License / Passport #					

Emergency Contact

Last Name		First Name	Middle Initial	Date of Birth
Address		City	State	Zip
Home Phone	Day Phone	Cell Phone	E-mail	
Relationship to patient:				

I/We do hereby consent to and authorize the **performance of all treatments and medical services** by the staff of Westchase Clinical Associates Inc. which they may deem advisable. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

I understand that the service fee for USCIS exam is for two (2) doctor visits, RPR (syphilis) test and PPD test (Tuberculosis skin test) and there are extra charges for more visits.

_____ I fully understand this agreement and consent will continue until cancelled by me in writing.
Initial

For minors:

_____ I authorize Westchase clinical Associates to render necessary medical treatment to the above named minor or whom I am the parent or legal guardian.

SIGNATURE:_____ **DATE:**_____

NAME (print):_____ **RELATIONSHIP:**_____

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USCIS Patients

Agreement of Financial Responsibility for USCIS patients **MR#: _____**

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Fees are payable when services are rendered. We accept cash and credit cards only.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID card for our records.
- The fee for your USCIS visit covers two visits and PPD (tuberculosis skin) test and RPR test (Syphilis test). If you require more visits you will be charged extra fees.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/ Responsible Party_____ Date_____

Westchase Clinical Associates

Name:_____ **MR #:**_____

Medication and Food Allergies

❑ **I do not have any known allergies**

1)_____ **2)**_____

3)_____ **4)**_____

Medications

❑ **I do not take any medications**

Name	**Dosage**
1)_____	_____
2)_____	_____
3)_____	_____
4)_____	_____

Medical History

❑ **No Past medical History**

1)_____ **2)**_____

3)_____ **4)**_____

Surgical History

❑ **No Past surgical History**

1)_____ **2)**_____

3)_____ **4)**_____

Vaccination records

(Please write any **documented** Vaccination. Per USCIS any prepared document has to be in English)

1) MMR **2) Tdap** **3)Varicella**

4) Influenza **5) Other**_____