Registration Form

Great Clinic
665 Roadsby Road
Longview, FL 333222
USA

Who

Title:
Name:
Preferred Name:
External ID: **DOB:**
Sex: **S.S.:**
License/ID: **Marital Status:**
User Defined:
Billing Note:
Gender Identity: **Sexual Orientation:**
Birth Name:
Previous Names:

Contact

Address: **Address Line 2:**
City: **State:**
Postal Code: **Country:**
Mother`s Name: **Emergency Contact:**
Emergency Phone: **Home Phone:**
Work Phone: **Mobile Phone:**
Contact Email: **Trusted Email:**

Additional Addresses NONE

County:

Choices

Provider:		**Provide Since Date:**	
Referring Provider:			
Pharmacy:			
HIPAA Notice Received:		**Allow Voice Message:**	
Leave Message With:		**Allow Mail Message:**	
Allow SMS:		**Allow Email:**	
Allow Immunization Registry Use:		**Allow Immunization Info Sharing:**	
Allow Health Information Exchange:		**Allow Patient Portal:**	
Prevent API Access:	☐	**CMS Portal Login:**	
Immunization Registry Status:		**Immunization Registry Status Effective Date:**	
Publicity Code:		**Publicity Code Effective Date:**	
Protection Indicator:		**Protection Indicator Effective Date:**	
Care Team (Provider):		**Care Team (Facility):**	
Care Team Status:		**Patient Categories:**	

Employer

Occupation:		**Employer Name:**	
Employer Address:		**Employer Address Line 2:**	
City:		**State:**	
Postal Code:		**Country:**	
Industry:			

Stats

Language:			
Ethnicity:		**Race:**	
Nationality:		**Family Size:**	
Financial Review Date:		**Monthly Income:**	
Homeless, etc.:		**Interpreter:**	
Migrant/Seasonal:		**Referral Source:**	
VFC:		**Religion:**	

Misc

Date Deceased:	
Reason Deceased:	

Guardian

Name:		**Relationship:**	
Sex:		**Address:**	
City:		**State:**	
Postal Code:		**Country:**	
Phone:		**Work Phone:**	
Email:			