DR. J. COOPER MCKEE M.D.

REGISTRATION FORM

Today's date:					PCP:								
	ng Commer, meny seria MMT belongs and designed a		PATIE	NT	INFORMA"	TION							
Patient's last name:		First: Middle:		O M		☐ Miss ☐ Ms.		Marital status (circle one) Single / Mar / Div / Sep / Wi					
Is this your legal name?	If not,	what is you	legal name?	(Former name	······································			Birth /	date:		Age:	Sex:
Street address:	gatera delimentalizate de la companya de la company	teturing brooms regularing describeration	nergit verste kulov (11886 et et versus 175 es az park	nytastokoblecep	Social Sec	urity no).;	**************************************	Angamung ganguraga	Home (pho)	ne no.:	er (() () () () () () () () () () () () ()
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Chose clinic because/Re	erred to c	inic by (plea	ise check one b	ox):	□ Dr.					O Ir	nsura	nce Plan	☐ Hospita
☐ Family ☐ Friend	0 (Close to hor	ne/work	OY	ellow Pages	(00	ther	rainte-transcript	al income! I manifestate and more than	nection begins	Paglacetaeth change chân baideathainn ac	Company and an array of the contract of the co
Other family members se	en here:			**********		androja saje saje jetoja					· harmana		Ohaliya (mahandiya karayan karana maha
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Person responsible for bill: Birth date: Address (if different):			CONTRACTOR AND THE STREET AND ASSOCIATION OF A SECURIT	Home phone no.:									
Is this person a patient he	ere?	Yes 🗆 N)	Construction Congress	**************************************		*************	0-7-1-2-10-10-10-10-10-10-10-10-10-10-10-10-10-	anne dispersion	and the second contract of the	in in september 10	(connect of the political set, the particular	ne, recent en la contract l'entre representative des rec
Occupation: Em	ployer:	oyer: Employer address:				Employer phone no.:							
ls this patient covered by insurance?		☐ Yes	□ No				*******************	en e	ofering an electric region	dente a anno e			
Please indicate primary ir [Insurance]	surance [insurance	☐ [Insurar e]	ce] [[rance] Welfare (Ple oupon)	(Insura ase pro				(Insuran Other	ce]	0[Insurance]
Subscriber's name:		Subscribe	r's S.S. no.:	Birt	h date:	Group	no.			Policy	no.:		Co- payment: \$
Patient's relationship to s	ubscriber:	☐ Self	☐ Spou	se	□ Child	Oth	er						
Name of secondary insurance (if applicable): Su		Subscriber's n	ubscriber's name:				C	Group no.:			Policy no.:		
Patient's relationship to s	ubscriber:	☐ Sel	f 🖸 Spou	se	□ Child	Oth	er						
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Name of local friend or re	ative (not	living at san	ne address):		Relationship	to patie	nt:	H (lome p	hone no	.:	Work ph	one no.;
The above information is that I am financially respondequired to process my classifications.	nsible for a												
Patient/Guardian sign	ature	and the state of t	the control of the first of the section of the sect	and planning to a garden	tantaga jajan kuja kenoni kataran jaja peringikan munisti ka	erican riving	Tauthers		Date	***************************************	P protection as a	ng ng galawa na ngapar ng garaning na na pingara	Proprietario de la companya de constante de la

Dr. J. Cooper McKee Health Questionnaire

Reason for Visit:	-	·····			-
	ONS: (indicate the year of h	ospitalization a	ind the reas	on, DO NOT include	norn
pregnancies)					
Year:	Illness or Operation	!	٠.		•
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		/			
			•		
Drug Allergies: *	*Please Circle all tha	ıt apply**	Please	list others:	
Penicillin	Tetanus				
renicillin	ietanus				•
Anesthetics	Antitoxin and Serun	ıs			•
Aspirin	lodine		•		
- -		4			
Pain Medications				• •	
			:		
				And the second second	
labits:					
Cigarettes: How r	nany packs a day? _	How Lo	ng?	Quit Date?	
<u>viconoi</u> : now mar	ny drinks per week? _		······		
Coffee: How many	vicuns nor day?				

Dr. J. Cooper McKee M.D.

I hereby give permission to Dr. J. Cooper McKee, M.D. and staff to disclose and discus any information

WHO TO CONTACT:

	•			
Name:	Relationship:	Phone Nun	nber:	
		· · · · · · · · · · · · · · · · · · ·	·	
				argument waster
			*	
I do not wish to give pe	rmission for additional fa	amily membe	ers, relativ	es, o
close personal friends to	have access to any info	rmation regu	arding my	Ţ
medical condition(s)				
•	•			
HOW TO CONTACT:				
wish to be contacted in the follow	wing manner:	. *		
	·			
			•	
Home #:	Cell #:			
		me or cell pl	in ana	30r
		me or cell pl	none numi	oer.
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∃ It is okay to leave a det	ailed message on my ho	me or cell pl	none numi	Jer. Zip
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	tailed message on my ho home address Street orization is indefinite uni	city less otherwi	State se revoked om persor	Zip d in ns no:

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

Name: _			
Birthdat	te:	SSN#:	
Lunders	tand that as part of my	healthcare, this organiza	ition originates and
maintaiı	ns health records for fut	ure care or treatment.	
l unders	tand that this information	on serves as:	
•	A basis for planning m	y care and treatment.	
•		ation among the many h	ealthcare professionals who
•	A source of informatio to my bill.	n for applying my diagno	sis and surgical information
•	A means by which a th actually provided.	nird-party payer can verif	y that services billed were
•		thcare operations such a ence of healthcare profes	s assessing care quality and
l unders	tand that I have the righ	·-	
•	_	o how my health informat	tion may be used or
			ealthcare operations and
		· · · · · · · · · · · · · · · · · · ·	o the restrictions requested.
•			xtent that the organization
÷		on in restrictions to the ı	ise of disclosure of my
	health information.		
practitione	rs of this medical office to ren	s, including physicians, physicinder routine medical care to the uding consultants, associates,	an assistants, and nurse e patient indicated on this form and and assistants of the physicians
Sig	nature of Patient, Parent or Le	egal Guardian	Date
f the Patie	nt is a Winor:	4.1	
Lo	onsent for	to authorize evaluation and tre	eatment for my child named herein
vhen I am	not available. I understand th	at this authorizes the person(s) named above to consent to
	d surgical procedures for the o		
The	Duration of this consent is in	idefinite and continues until re	voked in writing. I understand that
y not signi mergency.	•	vill not be provided medical car	e except in the case of an
mergency.		· · ·	
Sig	nature of Patient, Parent or Le	egal Guardian	Date