**SUNFLOWER HEALTH & WELLNESS CONSULTANTS, PC**

**501 N. Frederick Ave. Ste. 320**

**Gaithersburg, MD 20877**

**240-631-0200 Phone / 240-631-0300 Fax**

**PATIENT REGISTRATION FORM**

***Please Print All Information Clearly***

*Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_*

*Last First M.I.*

*What name do you prefer to be called? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_\_ Domestic Partner \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_\_*

*Ethnicity: Hispanic or Latino \_\_\_\_\_\_\_ Not Hispanic or Latino \_\_\_\_\_\_\_*

*Race: White \_\_\_\_\_\_ Black/African American \_\_\_\_\_\_ Asian \_\_\_\_\_\_ American Indian or Alaska Native \_\_\_\_\_\_*

*Native Hawaiian or Other Pacific Islander\_\_\_\_\_\_ Declined to Specify \_\_\_\_\_\_*

*Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Phone (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message ok? \_\_\_\_\_*

*(C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message ok? \_\_\_\_\_*

*(W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message ok? \_\_\_\_\_*

*Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Patient Portal? Yes No (Please circle one)*

*Would you like to receive our E-Newsletter? Yes No (Please circle one)*

*Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name/Relationship Phone*

*I was referred to this office by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Inclement Weather***

Although we make every effort to remain open, in the interest and welfare of our staff and patients there are times when our office may close due to inclement weather conditions. If you have a scheduled appointment in times of bad weather, please call ahead to verify that the office is open. ***W***e ***do NOT follow the school, state or federal government schedule.***

***Spouse or Responsible Party Information***

*Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Male\_\_\_\_ Female\_\_\_\_*

*Last First M.I.*

*Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ext. \_\_\_\_\_\_\_\_*

*Address: City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**CONSENT TO TREAT**

I hereby present to this office on a voluntary basis for the purpose of obtaining an examination and/or treatment. I hereby grant this office and its providers the authority to examine, evaluate, render treatment, provide recommendations, and/or order any examinations or tests necessary in the process of my examination and/or any subsequent treatment. I understand that there are certain risks associated with any examination or treatment. I understand that the practice of medicine is not an exact science and that there are no guarantees of the results and that every individual may respond differently to a particular procedure and/or treatment regimen. I understand that my authorization for treatment remains in effect until which time I notify this office and/or its providers of my intent to discontinue treatment.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature Date*

**PATIENT’S RESPONSIBILITY FOR PAYMENT**

As a service to our patients, Sunflower Health & Wellness Consultants, PC will submit charges for medical treatment to our patient’s insurance company. However, if the insurance company denies payment or will only pay a portion of the medical bil, the patient is responsible for payment of the account balance. If the patient has NOT met his or her deductible the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does NOT pay.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature*  *Date*

**ELECTRONIC PRESCRIPTIONS**

Sunflower Health & Wellness Consultants’ providers participate in electronic prescribing. By giving your consent below you agree that your prescriptions may be sent electronically and that we may request and use your prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. This includes your insurance company’s medication formulary.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature Date*

***PHARMACY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***PHONE*** *#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**SHWC NO SHOW POLICY**

In order to provide the best care possible we need you to show up for your appointments. In the event that you are not able to keep your appointment time please call or email us 24 hrs in advance to cancel. If you have an emergency and are unable to give us 24 hrs notice, please call as soon as you know you will not be able to make it. If you do not show up for your appointment and you have not contacted the office you will be charged **$50**. That charge will need to be paid prior to or at the next appointment time. We appreciate your understanding of the value of our time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature Date*