

- Care Station I
- Care Station II
- Care Station III
- Care Station IV

REGISTRATION AND CONSENT FORM

Date: _____

First Name: _____ M _____ Last: _____

Address: _____ Marital Status: Single Married Other

City/State/Zip: _____ Sex: Male Female

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Soc. Sec. #: _____

Are you under 18? Check here if no *If yes, please fill out below info:*

Guarantor First Name: _____ M _____ Last: _____

Check here if address is the same as above *If not, please fill out below info:*

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Soc. Sec. #: _____

If you have insurance, please fill out the following:

Insurance Carrier: _____ Insured ID: _____

Insured Party Name: _____ Group #: _____

Date of Birth of Insured Party: _____

CONSENT FOR TREATMENT AND RELEASE OF MEDICAL RECORDS

I give my permission to Care Station and its staff to perform upon me the following procedures IF DEEMED NECESSARY: the taking of health history, physical examination or diagnostic procedures including x-ray, electrocardiogram, audiogram, pulmonary function and venipuncture (drawing of blood) for laboratory tests and treatment for my injury / illness. If I should become ill while undergoing treatment by Care Station and it's staff, I give Care Station and it's staff my permission to administer treatment which they consider necessary for my well being.

I understand that information regarding the results of my physical exam, diagnostic procedures and / or nature of my illness will be released to the insurance carrier providing coverage to me. I consent to have my medical information transferred to any physical and/or health care institution that I am referred to by Care Station. I understand medical information will be communicated to a designated representative of my employer (only if this is a worker's compensation of an employer paid physical examination service).

My signature or mark indicates that I have read and understood this consent, and I consent to treatment.

Patient / Guardian Signature: _____