ST. GEORGE'S MEDICAL CLINIC

1750 East Colorado Boulevard | Pasadena, California 91106
Tel: (626) 440-0097 | Fax: (626) 440-0102

PATIENT REGISTRATION

Date:

PATIENT INFORMATION

Full legal first name | Middle name | Last name | Nickname (if applicable)

Street address / apartment | City | State | ZIP code

Date of birth (MM/DD/YYYY) | Age | Sex: M / F | Social Security number | Driver's license number / state

Marital status: S / M / D / W | Home phone | Business phone | Cell phone

Email address | Occupation

EMPLOYER INFORMATION

Employer name | Manager name | Manager phone

Employer street address | City | State | ZIP code

How did you hear about us? / Referred by

PARENT / SPOUSE INFORMATION

First name | Middle name | Last name | Home phone

Cell phone | Address (if different from above) | City | State | ZIP code

Date of birth | Social Security number | Occupation

Employer name | City | State | ZIP code | Business phone | Ext.

EMERGENCY CONTACT

Person to notify in case of emergency | Relationship to patient

Street address | City | State | ZIP code | Phone

Patient signature (or parent / guardian for a minor) | Date (MM/DD/YYYY)

ST. GEORGE'S MEDICAL CLINIC

1750 East Colorado Boulevard | Pasadena, California 91106
Tel: (626) 440-0097 | Fax: (626) 440-0102

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient full legal name

Date of birth (MM/DD/YYYY)

Employer / authorized recipient of information

I, the undersigned, hereby authorize St. George's Medical Clinic to release to the recipient identified above medical findings, examinations and test results, including drug test and other substance screening results, for the purposes of determining eligibility for employment or continued employment or restriction thereon.

I understand that every effort shall be made to maintain proper confidentiality of this information.

I understand that St. George's Medical Clinic may not condition treatment of me on whether or not I sign this authorization; however, I also understand that refusal to sign this authorization may affect my eligibility for employment per my employer's policies.

I further release St. George's Medical Clinic, its agents and employees from any claim or liability arising from providing such information to my employer.

I acknowledge that this authorization shall remain valid for a period of two (2) years from the date set forth below or until revoked in writing to St. George's Medical Clinic.

I further acknowledge that I understand that the medical exam I receive at St. George's Medical Clinic is solely for the purpose of determining my capabilities to perform certain job functions and is **NOT** a comprehensive medical examination. I understand that I should consult my personal physician for all personal health matters.

I have read this authorization or have had it read to me. I understand its contents and sign this authorization freely and voluntarily.

Patient signature

Date (MM/DD/YYYY)