Farragut
Medical and Travel Care

815 Connecticut Avenue, NW, Washington, D.C. 20006
Telephone: 202-775-8500 Fax: 202-775-2464
www.farragutmedical.com

Patient Name Last, First	Today's Date	Date of Birth	Sex	Age
Parent/Guardian, if Patient is a Minor				
Current Address	City	State	Zip	
Mailing Address, if Different	City	State	Zip	
Best Number(s) to Reach you				
E-Mail Address				
Occupation	Employer's Name			
How did you hear about us?	**Yelp or Google** (circle one)			

NOTIFY IN CASE OF EMERGENCY

Name	Telephone	Relationship

FINANCIAL INFORMATION:PERSON RESPONSIBLE FOR FEES

Were you injured on the job?	**Yes**	**No**
Are you being seen due to an auto accident?	**Yes**	**No**
Are you a **Medicare** participant?	**Yes**	**No**

ELECTRONIC MEDICAL RECORD & PRACTICE FUSION CONSENT

We have begun using **Practice Fusion**, a new electronic medical record (**EMR**) that can give you access to parts of your medical record. Please let us know if you would like access to your Patient Fusion portal and we will give you a PIN number as you leave our office.
I would like a PIN to have access to my own patient records
(circle one) **YES** **NO**

I request and consent to any and all care, medications, tests, and treatment(s) considered necessary by the attending practitioner for me or the above named patient. I understand that if I leave Farragut Medical & Travel Care without a practitioner's consent, I do so at my own risk and hereby relieve the practitioner and Farragut Medical & Travel Care of all responsibilities for my action. This Agreement applies to this and all future visits.
I understand that all charges **must** be paid for at the time services are rendered.

I have been given the opportunity to or have reviewed FMTC's office policy "Notice of Privacy Practices" as required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signed: _____Date_____
Patient
Signed: _____Date_____
Parent/Guardian (If patient is a minor)