Patient's Name (Last name, First name): _____

DOB: (MM/DD/YYYY): _____ **Gender: M or F**

Address: _____

_____

Phone: _____ **Ethnicity: Hispanic or Not Hispanic**

Race: **African American** **American Indian** **Asian** **Black**

European **Middle Eastern or North African** **Other** **White**

If student/faculty, name of school: _____

Patient's Primary Care Provider: _____

If you do not have a primary care provider, would you like to be contacted to be scheduled with a Primary Care Provider? Yes or No

Is the patient a United States Veteran? If yes, would you like to be contacted by the Veterans Association (VA) with more information regarding health care options?
Yes or No

AUTHORIZATION TO TREAT

Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing and procedures that are deemed necessary in the course of my care.

I have read and understand the policy and agree to abide by its guidelines:

_____ __/___/___ _____ ___/___/___

Patient Signature **Date** **Patient Name (Print)** **Date of Birth**

If patient is under 18 years of age, please complete:

_____ __/___/___ _____

Authorized Representative Signature **Date** **Authorized Representative Name (Print)**

Relationship to patient: _____ Phone number: _____

Driver's License/State ID Number : _____ State: _____

Test results will be provided to the Authorized Representative (parent or legal guardian of patient).