Patient Registration

Last Name:_____ First Name & MI:_____ DOB:_____

Address:_____
Street City, State, Zip

Cell #:_____ Email Address:_____

Social Security #:_____ Sex: M/F

Emergency Contact Information

Name:_____ Relationship to Patient: _____ Phone:_____

Individual PHI Release

The following individuals may have information regarding my treatment without restriction:

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

The above information is true to the best of my knowledge. I authorize the release of records to my insurance company listed for claims purposes and insurance benefits to be paid to Helix Health. I understand I am financially responsible for any balance. I understand the privacy policies in place at Helix Health. I understand that I can request a copy of those policies at any given time.

Signature:_____ Date:_____

Helix Health – Carriage Hills Dr. Ste. B, Paragould, AR. 72450 – 870.236.2911

Who can we THANK for referring you to Helix Health? _____