The James B. Haggin Memorial Hospital Community Health Fair 2017

Patient Registration Form

Name: _____
First Middle Last

Address: _____
Street

_____
City County State Zip Code

Phone: _____

Email: _____

Date of Birth: _____

Race: ☐ Hispanic ☐ Non Hispanic

Sex: ☐ Male ☐ Female

Physician's Name: _____
First Last

Physician's Address: _____
Street

_____
City County State Zip Code

Physician's Phone: _____

Emergency Contact: _____ Phone: _____

Test(s) Chosen

Select Test(s): ☐ Blood Test ($ 20.00) ☐ PSA (Additional $ 5.00)

I hereby give my consent to have a sample of my blood drawn for the purpose of laboratory test(s) that I have chosen.

I hereby release The James B. Haggin Memorial Hospital and any other organization(s) associated with this screening, their affiliates, directors, officers, employees, successors, and assigns, from any and all liability arising from or in any way connected with these tests or the test results. I understand that: 1. The data derived from a test is considered preliminary only and is not considered a diagnosis. 2. The responsibility of initiating a follow-up examination to confirm the results of a test and obtain professional medical assistance is mine alone, and not that of any organization(s) associated with these screenings.

Signature: _____ _____ Witness: _____
Date

☐ Basic Lab Work Package ☐ PSA