

Holistic Medical Center of Alabama

12205 County Line Road, Suite E, Madison, AL 35758

Phone: 256-325-1648 Fax: 888-477-8452 Email: info@holisticalabama.com

Registration Information

Date: _____

Patient:

First Name Middle Initial Last Name

Street Address City State Zip Code

Phone: () _____ - _____ Birth Date: ____/____/____ SS#: _____ - _____ - _____

Sex: ___M ___F Marital Status: ___Single ___Married ___Divorced ___Widowed

Race: ___Hispanic ___White ___Black ___Asian ___Indian ___Other: _____

Are you seeking a Primary Care Physician? ___Y ___N If not, who is your Primary Care Physician:

Work Phone: () _____ - _____ Cell Phone: () _____ - _____

In Case of Emergency Contact:

Name: _____ Relationship: _____

Home Phone: () _____ - _____ Work Phone: () _____ - _____

Planned Payment Method:

We require that all services be paid in full at the time of your visit. We do not accept any insurance for services provided. If paying by check or credit card please provide your driver's license number on check.

___Check ___Credit Card (Visa/MasterCard/Discover/AMEX) ___Cash

How Did You Hear About Us?

Email Address:

Consent to Provide Treatment:

I hereby consent to allow Rodney D. Soto, M.D. to provide medical care, including but not limited to treatments, examinations, and diagnostic procedures. I may rescind this consent at any time. If patient is a minor, please provide parent/guardian's signature.

Patient/Parent/Guardian

Date