Patient Registration

Patient Information			
Last Name: First: MI:		Sex: ❒M ❒F DOB: / /	
		Social Security #:	
Street Address:	City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	Other Phone: ( )
Home Email:	Confidential Email:		
Would you like to receive information by email? ❒ Yes ❒ No	Send to: ❒ Home email ❒ Confidential email		
Do you have a Primary Care Physician? ❒ Yes ❒ No	If yes, who is your PCP?		
PCP's address and phone number:			
Would you like a copy of today's visit sent to your PCP? ❒ Yes ❒ No			
Reason for today's visit:	How did you hear about us?		

Emergency Contact Information			
Emergency Contact Name:		Relationship to Patient:	
Street Address:	City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	Other Phone: ( )
What is the best number to contact you: ❒ Home ❒ Cell ❒ Work ❒ Other: ( ) -		What is the best time to contact you:	
May we leave a message on your Voicemail/Answering Machine ? ❒ Yes ❒ No			
May we leave a message with someone other than you? ❒ Yes ❒ No Who?:			

Employment Information	
Employer Name:	Occupation:
Spouse's Employer:	Spouse's Work Phone:

Insurance Information (Complete if Subscriber is not the Patient)			
Insured's Last Name: First: MI:		Sex: ❒M ❒F DOB: / /	
		Employer:	
Insurance Company:		Insurance Address:	
Subscriber ID:		Group Number:	

The above information is true to the best of my knowledge.

_____ _____

Signature of Patient/Guardian

Date