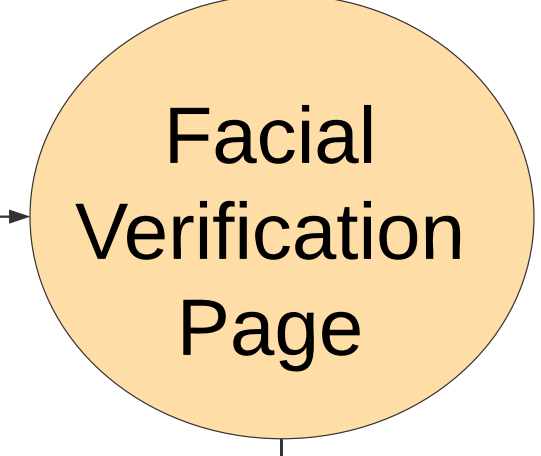


# Patient Registry

Patient Name	Choose... ▼
DOB	
Sex	
Gender	
Race	
Hispanic Origin	
Weight	
Height	
Reason for Visit	
Drivers License	
Primary Physician	
Proof of Insurance	
Secondary Proof of Insurance (optional)	
Medical History [Add/Edit Entries]	
Past Medication [Add/Edit Entries]	
Current Medication [Add/Edit Entries]	

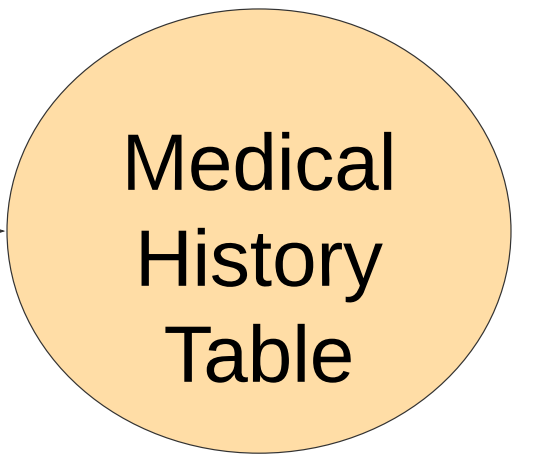
[Show Edit History]

+ Add as New Patient

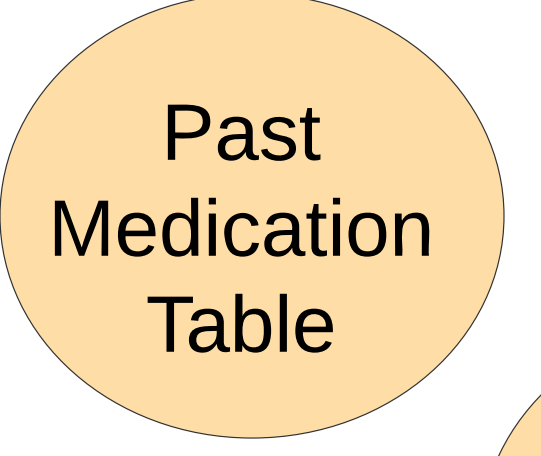


If used, then redirect to here

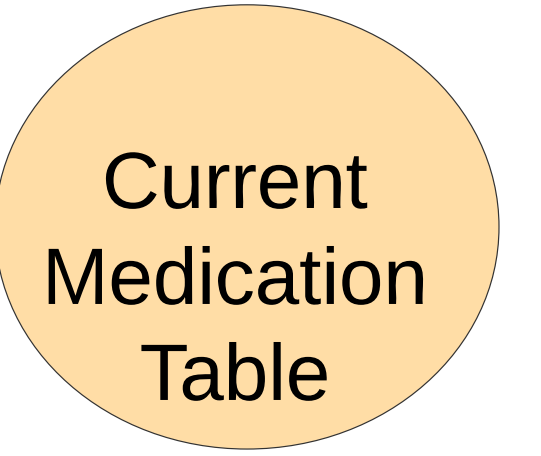
If verified, then fill out boxes



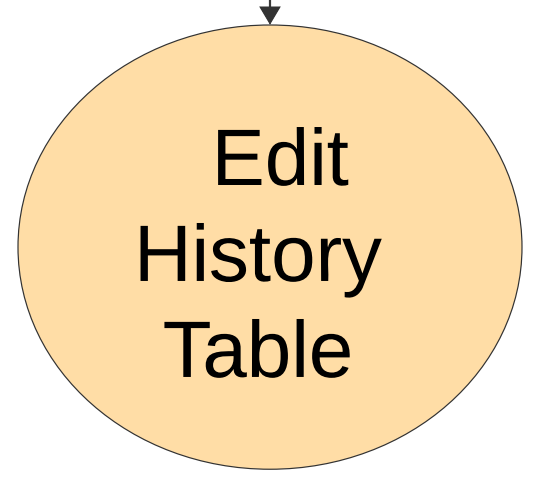
If clicked, then send to here



If clicked, then send to here



If clicked, then send to here



Redirect to here