PATIENT REGISTRATION FORM

SECTION A: PATIENT INFORMATION

First Name:	Michael	**Last Name:**	Thompson
Middle Name:	James	**Date of Birth:**	03/15/1985
SSN:	***-**-4589	**Patient ID:**	PT-2024-78542

Gender:	◉	Male	○	Female	○		
Marital Status:	○	Single	◉	Married	○	Divorced	○

SECTION B: CONTACT INFORMATION

Street Address:	4521 Oak Ridge Boulevard, Apt 12B
City:	Austin
State:	Texas
ZIP Code:	78745

Home Phone:	(512) 555-1234	**Cell Phone:**	(512) 555-9876
Work Phone:	(512) 555-4567	**Email:**	m.thompson@email.com

SECTION C: EMERGENCY CONTACT

Contact Name:	Sarah Thompson	**Relationship:**	Spouse
Phone Number:	(512) 555-2468	**Alt. Phone:**	(512) 555-1357

SECTION D: INSURANCE INFORMATION

Insurance Company:	Blue Cross Blue Shield	**Policy Number:**	BCB-78542136
Group Number:	GRP-45892	**Subscriber ID:**	SUB-123456789
Subscriber Name:	Michael J. Thompson	**Subscriber DOB:**	03/15/1985

SECTION E: MEDICAL HISTORY

Primary Physician:	Dr. Robert Williams	**Physician Phone:**	(512) 555-8900
Preferred Pharmacy:	CVS Pharmacy #4521	**Pharmacy Phone:**	(512) 555-7890

Do you have any of the following conditions? (Check all that apply)

☒	Diabetes	☒	Hypertension	☐	Heart Disease
☐	Asthma	☐	Arthritis	☐	Cancer
☐	Thyroid Disorder	☐	Kidney Disease	☐	Liver Disease

☐	Depression	☐	Anxiety	☐	Other

Current Medications:	Metformin 500mg, Lisinopril 10mg, Aspirin 81mg
Known Allergies:	Penicillin, Shellfish

SECTION F: LIFESTYLE INFORMATION

Do you smoke?	○	Yes	◉	No	○
Do you drink alcohol?	○	Yes	○	No	◉
Do you exercise?	◉	Regularly	○	Occasionally	○

SECTION G: REASON FOR VISIT

Reason for Visit:	Annual Physical Examination
Symptoms Description:	Occasional fatigue, routine checkup for diabetes management
Symptom Duration:	2-3 weeks

SECTION H: CONSENT & AUTHORIZATION

☒	I consent to receive medical treatment as deemed necessary by my healthcare provider.
☒	I acknowledge receipt of the Notice of Privacy Practices (HIPAA).
☒	I authorize the release of medical information for billing and insurance purposes.
☒	I accept financial responsibility for charges not covered by my insurance.

Patient Signature:	Michael J. Thompson	**Date:**	11/26/2025
Guardian Name:	N/A	**Relationship:**	N/A

FOR OFFICE USE ONLY

Received By:	Jane Smith, RN	**Date/Time:**	11/26/2025 09:30 AM
Verified By:	Mary Johnson	**MRN:**	MRN-2024-785421