

PATIENT REGISTRATION FORM									
SECTION A: PATIENT INFORMATION									
First Name:					Last Name:				
Middle Name:					Date of Birth:				
SSN:					Patient ID:				
Gender:				Male				Female	
Marital Status:				Single				Married	
								Divorced	
SECTION B: CONTACT INFORMATION									
Street Address:									
City:									
State:									
ZIP Code:									
Home Phone:					Cell Phone:				
Work Phone:					Email:				
SECTION C: EMERGENCY CONTACT									
Contact Name:					Relationship:				
Phone Number:					Alt. Phone:				
SECTION D: INSURANCE INFORMATION									
Insurance Company:					Policy Number:				
Group Number:					Subscriber ID:				
Subscriber Name:					Subscriber DOB:				
SECTION E: MEDICAL HISTORY									
Primary Physician:					Physician Phone:				
Preferred Pharmacy:					Pharmacy Phone:				
Do you have any of the following conditions? (Check all that apply)									
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Heart Disease				
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Cancer				

	Thyroid Disorder		Kidney Disease		Liver Disease
	Depression		Anxiety		Other
Current Medications:					
Known Allergies:					
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:					
Symptoms Description:					
Symptom Duration:					
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:				Date:	
Guardian Name:				Relationship:	
FOR OFFICE USE ONLY					
Received By:				Date/Time:	
Verified By:				MRN:	