

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)

	Diabetes		Hypertension		Heart Disease
	Asthma		Arthritis		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:		
<i>FOR OFFICE USE ONLY</i>							
Received By:				Date/Time:			
Verified By:				MRN:			