

# 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
<b>Current Medications:</b>					
<b>Known Allergies:</b>					
<b>SECTION F: LIFESTYLE INFORMATION</b>					
<b>Do you smoke?</b>		Yes		No	
<b>Do you drink alcohol?</b>		Yes		No	
<b>Do you exercise?</b>		Regularly		Occasionally	
<b>SECTION G: REASON FOR VISIT</b>					
<b>Reason for Visit:</b>					
<b>Symptoms Description:</b>					
<b>Symptom Duration:</b>					
<b>SECTION H: CONSENT &amp; AUTHORIZATION</b>					
	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.				
<b>Patient Signature:</b>				<b>Date:</b>	
<b>Guardian Name:</b>				<b>Relationship:</b>	
<i>FOR OFFICE USE ONLY</i>					
<b>Received By:</b>			<b>Date/Time:</b>		
<b>Verified By:</b>			<b>MRN:</b>		