

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					
<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	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:		