

| 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: | | |
| | | | | | |