PATIENT REGISTRATION RECORD

Pt. Rec #_____

PATIENT'S LAST NAME, FIRST NAME, MI (PLEASE PRINT)	MARITAL STATUS				SEX		BIRTH DATE (MM/DD/YY)	AGE	RELIGION (OPTIONAL)
	S	M	W	D	M	F			
STREET ADDRESS PERMANENT TEMPORARY	CITY AND STATE						ZIP CODE	HOME PHONE #	
EMAIL:	CELL PHONE #								
PATIENT'S EMPLOYER (IF STUDENT, NAME OF SCHOOL)	OCCUPATION (INDICATE IF STUDENT)						BUSINESS PHONE #		
EMPLOYER'S STREET ADDRESS	CITY AND STATE						ZIP CODE		
DRUG ALLERGIES IF ANY	SOCIAL SEC #								
SPOUSE OR PARENTS NAME	NO. OF CHILDREN	PREFERRED COMMUNICATION METHOD ☐ PHONE ☐ E-MAIL ☐ MAIL ☐ TEXT							
SPOUSE OR PARENTS EMPLOYER (IF STUDENT, NAME OF SCHOOL)	HOW LONG EMPLOYED	BUSINESS PHONE #							
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE							

PRIMARY INSURANCE	INSURED'S EMPLOYER	
INSURED'S NAME	DATE OF BIRTH	SOCIAL SEC #
SECONDARY INSURANCE	INSURED'S EMPLOYER	
INSURED'S NAME	DATE OF BIRTH	SOCIAL SEC #
PERSON RESPONSIBLE FOR ACCOUNT, IF NOT PATIENT	MAILING ADDRESS	

RELATIONSHIP TO PATIENT	EMPLOYER'S NAME AND ADDRESS		WORK PHONE #
PERSON TO CONTACT IN CASE OF EMERGENCY	RELATIONSHIP TO PATIENT	HOME PHONE #	WORK PHONE #
HAS ANY OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN BEFORE?			
REFERRED BY	YOUR FAMILY DOCTOR		OFFICE PHONE #
PHARMACY NAME	PHARMACY FAX #		PHARMACY PHONE #

I WOULD YOU LIKE TO HAVE AN ASSISTANT IN THE ROOM WITH THE DOCTOR DURING YOUR EXAMINATION?	FOR OFFICE USE ONLY	
YES_____ NO_____ NO PREFERENCE_____	CO-PAY	OUT OF POCKET
SIGNATURE_____	DEDUCTABLE	

I authorize the release on any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed_____ **Date**_____