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____