PATIENT REGISTRATION AND INFORMATION FORM

(PLEASE PRINT)

LAST NAME:________________________________FIRST NAME:___________________________MIDDLE INITIAL:______

HOME ADDRESS:____

CITY:____STATE:_________________________ZIP CODE:______________

HOME TELEPHONE #:____

☐ **O.K. to leave message with detailed information** __**or**__ ☐ **Leave message with call-back number only**

BUSINESS TELEPHONE #:____

☐ **O.K. to leave message with detailed information** __**or**__ ☐ **Leave message with call-back number only**

CELLULAR TELEPHONE #:____

☐ **O.K. to leave message with detailed information** __**or**__ ☐ **Leave message with call-back number only**

PAGER #:____

DATE OF BIRTH:______________________SEX:_______SOCIAL SECURITY #:_______________________________

MARITAL STATUS:_________________________SPOUSE'S NAME:____

TELEPHONE #:____

WHO SHOULD WE CONTACT IN EMERGENCY?____

THEIR HOME TEL.#:______________________________THEIR CELLULAR TEL.#:___________________________

ARE YOU EMPLOYED?______________IF SO, PLEASE COMPLETE BELOW:

YOUR EMPLOYER'S NAME:____

ADDRESS:____

YOUR EMPLOYER'S TELEPHONE #:____

__**NOTE: IF YOUR VISIT IS RELATED TO A WORK OR AUTOMOBILE ACCDENT YOU MUST ADVISE RECEPTIONIST**__

NAME OF THE PHYSICIAN WHO REFERRED YOU TO OUR OFFICE:____

REFERRING PHYSICIAN'S TELEPHONE #:____

IF THE ABOVE LISTED IS NOT YOUR PRIMARY CARE PHYSICIAN, PLEASE COMPLETE BELOW:

WHO IS YOUR PRIMARY CARE PHYSICIAN?____

YOUR PRIMARY CARE PHYSICIAN'S TELEPHONE #:____

YOUR PHARMACY NAME AND TELEPHONE #:____

BELOW FOR OFFICE STAFF USE ONLY

☐ NOTICE OF PRIVACY PRACTICES TO PATIENT ☐ SIGNATURE PAGE COMPLETED