PATIENT REGISTRATION

PATIENT INFORMATION				
Name				
DOB	Male / Female	Single	Married	Divorced
Address				
City		State		Zip
Home Phone	Cell Phone		Work Phone	
Email		Social Security #		
Office Use Only	*If patient is a minor, have all parents/guardians consented to treatment?*			*Yes* / *No*

EMERGENCY CONTACT INFORMATION			
Name			
Address			
City		State	Zip
Home Phone	Cell Phone	Work Phone	

PRIMARY CARE PHYSICIAN INFORMATION		
Name		
Address		
City	State	Zip
Phone	Fax	

PHARMACY INFORMATION	
Name	
Phone	Fax

HIPAA INFORMATION AND OFFICE POLICIES	
I have received, read, and understood the Notice of Privacy Practices effective 07/01/2010 and the current patient welcome letter.	
Signature	Date