Patient Registration Form

(PLEASE PRINT CLEARLY)

PATIENT'S FULL NAME: _____

AGE: _____DOB: _____ E-MAIL ADDRESS: _____

ADDRESS: _____CITY: _____STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PREFERRED PHONE FOR US TO CONTACT YOU AND/OR LEAVE MESSAGES: _____

MAY WE CONTACT YOU VIA (PLEASE CIRCLE ALL OPTIONS): EMAIL PHONE NO CONTACT

OCCUPATION: _____

IN CASE OF EMERGENCY, CONTACT: _____

RELATIONSHIPTO YOU: _____ EMERGENCY CONTACT PHONE: _____

PREFERRED PHARMACY: _____ PHONE NUMBER: _____

REFERRAL INFORMATION

How did you learn about our office? (Physician referral, friend, newspaper ad, radio, internet, other)

_____

We cannot render services on the assumption that our charges will be paid by an insurance company. Our services will be charged directly to the patient and he or she will be responsible for payment.

Patient Signature: _____ Date: _____