Patient Registration

Date	Physician	▢ New Patient ▢ Update ▢ Self Pay ▢ PPO
Patient Name	SS#	DOB
Race	Ethnicity	Language Preferred
Address	City	State&Zip
Mailing/Billing Address	City	State&Zip
Spouse's/Partner's Name		DOB

Employment status: ▢ Employed ▢ Unemployed ▢ Full Time Student ▢ Part Time Student ▢ Child ▢ Retired ▢ Other

To respect your privacy, please tell us which of the following we should use to communicate with you regarding appointment reminders, lab results, etc. Only check the contact information which you want us to use.

▢ Home _____ ▢ Cell _____

▢ Work _____ ▢ Email _____

Please provide your email address for our secure Patient Portal. Email: _____

Primary Care Physician		Phone
Address	City	State&Zip
Drug Allergies and Reactions		▢ No Known Allergies

Pharmacy Information

Pharmacy Name	Phone	Fax
Address	City	State & Zip

Emergency Contact

Name	Relationship (ie: partner/family/friend)	Emergancy Phone

Person Responsible for your bill

Name	Phone	DOB
Address	City	State And Zip

I understand that I am responsible for charges, deductibles and appropriate co-payments at the time of the service unless other arrangements have been made with the billing office. I authorize payment of medical benefits to be made to the physicial for the services rendered and I am resposnible for any payment and non-covered services.

Signature	Date

Authorization to Release Information

I hereby authorize the Physician to relase any information necessary accquired in the couse of my treatment to process insurance claims. I understand by not supplying complete insurance informatino I will be responsuble for my account balance.

Signature	Date