REGISTRATION

Complete and honest answers to the questions below are required to receive care at this clinic.
Please use black or blue ink only.

No information contained in this form is released to anyone without your written approval.

Patient Name (First MI Last): ____

Sex: M F **Age:** __________ **Date of Birth:** ______________________________

Home Phone: ______________________**Cell Phone**: ______________________**Work Phone:** _______________________

Mailing Address: ___________________________________**City:** ____________________**State:** _______**Zip:** _________

Street Address: ____________________________________**City:** ____________________**State:** _______**Zip:** _________

E-mail Address: ____

Social Security #: ___________________________________

Driver's License/State ID # (Copy Required): ____**State Issued:** _________

Marital Status: Single Married Widowed Separated Divorced Partner

Employer: ____

Address: ____**City:** _________________________**State:** ___________

Job Title: _______________________________________

Person to contact in an emergency: ____

Relationship to you: ____________________ **Major contact #:** ___________________ **Circle: Cell** or **Home**?

May we release information about your condition to this person? Yes No

Family Physician (Name & Location): ____

Referred By: ____May we thank this person for the referral? Yes No

I affirm the information above to be true and accurate to the best of my knowledge.

Signature of Patient/Guardian: ____**Date:** _____________________

(Parent or Guardian **must sign** if patient is under 18)