Patient Registration

Date of Visit:

Patient Information

Name:

Date Of Birth: Language:

Address: City/State

Home #: Cell #: Email:

Gender: Female Male Other Marital Status: M D S W

Race: [ ] American Indian [ ] Asian [ ]Black/African American [ ] Native Hawaiian [ ] White

[ ] Hispanic/Latino [ ] Refuse to Answer [ ] Other:

Emergency Contact Information

Name: Phone #:

Address:

Patient Past Medical History

Major Medical Problems:

Major Surgeries:

Current Medications:

Allergies to Medications: Pharmacy /Location

Social History Smoker: Y N Alcohol Consumption: Y N Recreational Drugs: Y N

Insurance Information

Insurance Company:

Subscriber Name:

Subscriber Date of Birth : Subscriber Social Security #:

Insurance Company Address:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Submit