🦷 PATIENT REGISTRATION FORM 🦷

Patient Information

Name (First): _____ (Last): _____ (Middle): _____

Address: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

SSN: _____ Occupation: _____

Phone (Cell): _____ (Home): _____ E-mail: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency contact: _____ Relationship: _____

Emergency contact phone: _____

If the patient is under the age of 18 (Minor) please provide information for the parent/legal guardian

Parent/legal guardian name: _____ Phone: _____

Insurance Information

Insurance Company: _____ Plan Name (if any): _____

Subscriber ID: _____ Group number: _____

Policy holder's name: _____ Relationship to patient: _____

Policy holder's DOB: _____ Policy holder's employer: _____

Medical History

Primary care physician: _____ PCP Phone number: _____

Preferred pharmacy: _____ Pharmacy phone number: _____

➡️ Please list any medications you are currently taking, prescribed or over the counter:

Medication	Dosage / Frequency	Purpose

Allergies to medications or food (list reactions): _____

➡️Please list any major surgeries or hospitalizations:

Surgery	Year	Complications

➡️Please list any family history of medical problems:

Person	Medical problem

Do you drink alcohol? ☐YES ☐NO

If so, how much: _____

Do you smoke cigarettes? ☐YES ☐NO

If so, how often: _____

Do you take recreational drugs? ☐YES ☐NO

Are you pregnant or nursing? (Females): ☐YES ☐NO

If so, how far along: _____

Signature

I certify that the above information is true and accurate.

_____	_____	_____
Patient/Legal guardian	Signature	Date