Date: _____ PATIENT REGISTRATION File #: _____

PATIENT INFORMATION

First Name: _____M.I. _____ Last Name: _____

Address: _____City:_____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email address: _____receive our newsletter by e-mail yes no

Birthdate: _____ Sex: _____ Social Security #:_____ Marital Status: _____

Employer: _____ Occupation:_____Address:_____

City: _____State: _____Zip: _____Work Status ___FT ___ PT ___

Retired Student ___FT ____PT School:_____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home phone: _____ Cell: _____ Work: _____

How did you hear about our clinic: _____

GUARANTOR INFORMATION (Responsible Party, if different from above)

First Name: _____M.I. _____ Last Name: _____

Address: _____City:_____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Birthdate: _____ S.S.#:_____ Sex :_____ Marital Status: _____

Employer: _____ Address: _____ City:_____

State: _____ Zip:_____ Work Status ___FT ___ PT ___Retired

MEDICAL HISTORY

What is the reason for your visit today: _____

_____

History of present illness: _____

History: ☐ Cancer ☐HTN ☐ Diabetes ☐Pacemaker ☐ Congestive Heart Failure ☐ Stroke ☐ Candida

☐ Other: _____

_____

List allergies to medications or substances: _____

If you take any medications check here: ☐ Medications will be listed on the next page.

SIGNATURES

I understand that payment is due at the time of service unless other arrangements have been made in advance. I agree that I am responsible for full payment of this account and any court costs and attorney fees associated with the collection of this account.

_____ _____

Responsible Party Date

_____ _____

Patient Date