PATIENT REGISTRATION **Date:_________________**

Name ____ Date of Birth: ____/____/____
First Middle Last

Marital Status: S M W D If Child, Parent(s) Name(s):_________________________________

Patient's Address:____

Cell Phone: ( )____-_____ Home Phone: ( )____- ______ Social Security # _____-____-_____

E-mail Address: ____

Emergency Contact Name, Relationship & Phone:____

Employer Name, Address, Phone:____

Family Doctor: _____________________________Preferred Pharmacy:_______________________

How did you hear about us?___Doctor ___Phone book ___Radio ___Another patient________________

RACE: ___White ___African Am ___Hispanic LANGUAGE: ___English ___Spanish ___Other_____________

FAMILY MEDICAL HISTORY: Diabetes, heart disease, stroke, bleeding disorder, cancer, etc.

Father's history: ____

Mother's history: ____

Siblings' history: ____

SOCIAL HISTORY: Smoke Y N ________ pks per day Alcohol Y N _______ oz per day

ALLERGIES: Please check those that apply to you and list type of reaction

______ NO KNOWN ALLERGIES _____ Cortisone ______ Latex ______ Local Anesthesia

______ Adhesive tape _____ NSAID's ______ Sulfa ______ Topical lotions/creams

______ Aspirin _____Iodine _____ Codeine ______ Penicillin Other: ___________________

Please describe reaction: ____

PREVIOUS HOSPITALIZATIONS/SURGERIES: ____

____

INSURANCE:_________________________ Subscriber: __________________DOB:___/___/_____

ID # ____________________ Group # ________________ Subscriber SSN ______-____-_______