Patient Registration Form

Patient Information:

____ Male ____ Female _____ Other ____ Single ____ Married

_____ Choose not to disclose

Last name : _____ First Name: _____ Middle Initial: _____

Complete Mailing Address:_____

_____

(Include any Apartment/Unit Numbers along with City, State and Zip Code)

Patients Date of Birth:_____

Driver's License Number or State ID/Issued by the State of : _____

Mobile Phone:_____ Home phone: _____

Work Phone: _____ Email: _____

**Please mark off authorizing consent to reach you (circle preferred method of contact) :*

___ *Mobile calls/voicemail/text* ____ *Home phone* ____ *Work Phone* ____ *Email*

Occupation: _____ Employer: _____

Emergency Contact: Name :_____ Relationship:_____

Telephone number (s): _____

Who is Legally Responsible For Payment On This Account:

___ Self ___ Spouse ___ Parents ____ Mother ____Father ___Other

Please Print Name of Responsible Party:_____

Best Contact Phone Number: _____

Address *(if different from the patient)*:_____

Email: _____

Relationship to patient:_____