Patient Registration Form

Patient name:_____ Todays date:_____

Street address, city, state, zip code:_____

Guarantor/responsible party/name of insured if different than above: _____

Home phone: _____Work phone: _____Cell phone:_____

Email address:_____

Date of birth:_____/_____/_____ Gender: Male Female

Marital status: Single Married Separated Divorced Widowed

Name of significant other if applicable:_____

Employer:_____ Part time Full time Retired

Occupation:_____

Emergency contact:_____

Relationship to patient: _____ Phone:_____

Referring physician name:_____ Phone:_____

Primary care physician name:_____ Phone:_____

_____ (initial here) By initialing this section and signing below, I acknowledge that I signed a copy of the MA notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full notice. I understand that a copy of the current notice will be available in the reception area, the website, and that any revised Notice of Privacy Practices will be made available upon request.

How did you hear about us? (Please select all that apply)

_____Friend/Family member	_____Doctor	_____Direct mail
_____Website	_____Facebook	_____Open House
_____Sign	_____Internet	_____Health Fair

Other:_____

We will make a copy of the front and back of your insurance card and driver's license or identification card for our records.

Signature:_____ Date:_____