# Patient Registration

Name: _____ ❑ Jr ❑ Sr
*First* *Middle* *Last*
Prefer to be called: _____ Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.
Social Security Number: _____
Date of Birth: _____/_____/_____ Sex: ❒ Female ❒ Male

Address: _____
*Street*
_____
*City* *State* *Zip*
*Other Address:*_____

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

CompanyName/Work Address: _____

Other family members that are patients _____

Referred by: _____

Primary Care Physician _____ Phone ( )_____

**EMERGENCY CONTACT INFORMATION:**
In case of Emergency, who should be notified?_____ Phone ( )_____

Do you give our office permission to discuss your medical information with family members? ❑ YES ❑ NO If yes, please provide their name and phone number.
Name: _____Relationship: _____ Phone (____)_____
**May we leave personal medical information on your answering machine or cell phone?** ❑ YES ❑ NO
**May we e-mail personal medical information to you?** ❑ YES ❑ NO

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:**
My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.
Patient or Responsible Party Signature _____ Date ___/___/___

_____ ___/___/____
**Signature of Patient** **Date**

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## Minor Patient Registration Form

Minor's Name: _____ Prefer to be called: _____

School:_____ Grade:_____

Legal Guardian or Parent Name: _____
First Middle Last

Phone # (day): _____ Phone # (evenings): _____