Patient Registration

	Account No. (Office Use Only)
Referred By	Date

How did you hear about us?

Would you like to be added to our mailing list? ☐ Yes ☐ No Thanks

Patient

Full Name			
Social Security No.	D.O.B.	Age	☐ Male ☐ Female
Home Phone	Work Phone	Fax Phone	
Cell Phone	Preferred Phone	Pharmacy Phone	
Email Address		Drivers License No.	
Mailing Address			
City, State, Zip			

Employment (if minor, responsible parties)

Employed By	
Position	May we call you at work? ☐ Yes ☐ No
Address	

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name	Social Security No.
Spouse's Employer	Phone No.
Address	

In Case of Emergency

Name	Relationship	Phone No.
Name	Relationship	Phone No.

I understand that I am financially responsible for all charges. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, money orders and most major credit cards.

Signature Date