

2: PATIENT REGISTRATION

Salutation: Sir Dr. Mrs. Mr. Ms. Other **New patient?** Yes No

First name

Middle name

Last name

Date of birth

Sex

Last 4 of SS

Home address

OK to call? Yes No

Cell phone #

OK to email? Yes No

Email

Marital status: Married Living with partner Single Divorced Widowed

Work/Career: Working Retired Disabled Student Other

In case of emergency, contact: Spouse Partner Friend Child

Name of emergency contact

Phone #

Primary care provider:

Name of primary care provider/practice

Phone #

Pharmacy

Name of pharmacy

Phone #

Specialist (orthopedist, neurologist, etc.)

Name of specialist

Phone #