

**Patient Registration Form**

**Patient ID#** \_\_\_\_\_

\_\_\_\_\_  
(First, Middle, Last, Suffix) (Date of Birth)

\_\_\_\_\_  Mr.  Mrs.  Ms.  Miss  Dr. \_\_\_\_\_  
(Preferred to be called) (Social Security Number)

\_\_\_\_\_  
(Mailing Address) (Home telephone #)  Male

\_\_\_\_\_  
(City, State, Zip) (Cell phone #) (Cell Phone Carrier)  Female

\_\_\_\_\_  
(E-mail Address)  Single  Married  Divorced  Widowed  Separated

**Employment Information**

\_\_\_\_\_  
(Occupation) (If **retired**, from what did you retire?) (Employer)  
\_\_\_\_\_  
(Address)  
\_\_\_\_\_  
(Work telephone number) (City, State, Zip)

**If patient is a minor,** \_\_\_\_\_  
(Name of parent or guardian) (Day telephone #) (Evening telephone #)

**As required by law, children under age 18 must be accompanied by a parent for their first visit.**

**Spouse's Information (if applicable)**

\_\_\_\_\_  
(Spouse's Name) (Spouse's Employer) (Spouse's Employer telephone #)

\_\_\_\_\_  
(Spouse's Date of Birth) (Spouse's Social Security Number) (Spouse's phone number)

**Reference Information**

\_\_\_\_\_  
(Primary Care Physician) (telephone #) (Pharmacy Name & Location) (telephone #)  
In case of emergency, whom should we notify? \_\_\_\_\_  
(Name) (Relationship) (telephone #)  
Responsible Party (if other than patient): \_\_\_\_\_  
(Name) (Relationship) (Daytime telephone #)  
\_\_\_\_\_  
(Mailing Address) (Employer) (Evening telephone #)  
\_\_\_\_\_  
(City, State, Zip) (Employer telephone #) (Social Security Number)

**CANCELLATION NOTICE:** We respectfully request that if you are unable to keep your scheduled appointment, please call us 24 hrs in advance to avoid a Missed Appointment fee. We can be reached at (325) 944-3376.

**SEE BACK** 

