DOC AT YOUR DOOR
Physician House Calls and More

PATIENT REGISTRATION

Patient Name: ____________________________________ **DOB:** __________________

Address: ____

Home Phone: _________________________ **Cell Phone:** _________________________

E-mail: _____________________________________ **Soc Sec #:** ____________________

Primary Care Physician: __ No __ Yes: _______________________________________

Health Insurance

- **Primary:** __ None __ Medicare Other: ____________________________
- **Secondary:** __ None __ Medicare Other: ____________________________

Next of Kin

Name: ________________________________ Relationship: _________________

E-Mail: ________________________________ Phone: ______________________

Emergency Contact

same as 'Next of Kin' above (skip this section)

Name: ________________________________ Relationship: _________________

E-Mail: ________________________________ Phone: ______________________

Responsible Party / Legal Representative / General Power of Attorney (if any)

none . . . I represent myself (skip this section)

same as 'Next of Kin' above (skip this section)

Name: ________________________________ Relationship: _________________

E-Mail: ________________________________ Phone: ______________________

Medical Power of Attorney (if any)

none (skip this section)

Name: ________________________________ Relationship: _________________

E-Mail: ________________________________ Phone: ______________________

____ ____________________

Patient Signature (or that of legal representative) **Date**

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