DOC AT YOUR DOOR
Physician House Calls and More

PATIENT REGISTRATION

Patient Name: _____ **DOB:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

E-mail: _____

Primary Care Physician: ___ No ___ Yes: _____

Health Insurance: ___ No ___ Yes: _____

Local Pharmacy: : ___ No ___ Yes: _____

Mail Order Pharmacy: : ___ No ___ Yes: _____

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**