Estelle Archer MD
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NEW PATIENT REGISTRATION FORM

(Please Print)

Today's Date : Former Primary Care Provider :

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
☐ Yes	☐ No					☐ M	☐ F

Street address:	Social Security no.:	Home phone no.:
		( )

P.O. box:	City:	State:	ZIP Code:

Email Address:	Cell phone no:	Work phone no.:
	( )	( )

Are you a student :	Full or Part time:	Is it ok to leave message at home or at work?
Occupation:	Employer:	Employer phone no.:
		( )
Spouse Full Name :	Spouses Date of Birth:	Spouse Phone no.:
		( )
Spouses Social Security no.:	Spouses Occupation:	Spouses Employer:

Chose clinic because/referred to clinic by (Please check one box):			☐ Dr.		☐ Insurance plan	☐ Hospital
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other		

Other family members seen by our practice: (This enables us to link charts of Spouses and minor children)	

ADDITIONAL INFORMATION

Preferred Local Pharmacy: Address: City:	Other Preferred Mail Order Pharmacy: Address: City:

Mail Order Pharmacy:	☐ Medco	☐Caremark	☐ Express Scripts	`☐ Other:	

Would you like to sign up for the web Patient Portal so you can view your Lab results?	☐ Yes	☐ No	

We are now required by CMS to collect information on race and ethnicity. How do you want to be listed?

☐ American Indian or Native ☐ Asian ☐ Black or African American ☐ White ☐ Hispanic ☐ Decline to State ☐ Alaskan ☐ Native Hawaiian ☐ Other:_______________

Any Special Needs?

IN CASE OF EMERGENCY

Emergency contact not living in household:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Amarillo Medical Specialists, LLP, my physician, or insurance company to release any information required to process my claims.

	Patient/Guardian signature		*Date*	