Patient Registration Form

Personal Information

1. Patient's Full Name: _____
2. Patient's Date of Birth (mm/dd/yyyy): _____
3. Gender: □ Male □ Female □ Other
4. Social Security Number (optional): _____
5. Marital Status: □ Single □ Married □ Divorced □ Widowed

Contact Information

1. Home Address: _____
2. City: _____ State: _____ Zip: _____
3. Cell Phone: _____
4. Email: _____

Emergency Contact

1. Full Name: _____
2. Relationship to Patient: _____
3. Contact Number: _____

Insurance Information

1. Insurance Company: _____
2. Policy Number: _____
3. Group Number: _____
4. Policy Holder's Name: _____
5. Policy Holder's Date of Birth (mm/dd/yyyy): _____

Health History

1. Primary Care Physician: _____
2. Date of Last Physical Examination: _____
3. Current Medications (if any): _____
4. Known Allergies (if any): _____
5. Chronic Illnesses (if any): _____
6. Previous Surgeries/Hospitalizations (if any): _____

We respect your privacy and commit to maintaining the confidentiality of your personal information; please refer to our Privacy Policy. Please note that by signing this form, you are consenting to the use and disclosure of your protected health information for the purposes of treatment, payment, and health care operations. I declare that the information provided by me in this form is accurate and true

to the best of my knowledge. I understand that providing false or inadequate information could result in unintended medication interactions or poor outcomes.

Signature: _____ Date: _____