Purity of Life

Meeting You Where You Feel @ Home!

PATIENT REGISTRATION FORM

PERSONAL INFORMATION (please print)

Name: ____ Date of Birth: ______/_______/_______
First MI Last

Address: ________________________________ Apt: _______ Age: ________ Sex ID: _____________

City: ______________________ State: _________ Zip: __________ Email: ______________________

Phone: Cell: (_______) _____________________ Alternate: (_______) _________________________

Referral source: ____

Occupation: ____

Best day(s) & time(s) for appointments: ____

Best time to contact you: ____

May we leave text messages or contact you via email? □ YES □ NO

PRIMARY HEALTH CONCERNS

1. ____
2. ____
3. ____
4. ____

EMERGENCY INFORMATION

Emergency Contact Person: ______________________________ Phone: (______) _________________

Relationship: ____

MEDICAL CONTACT:

Provider Details: ____

Address: ____

City: __________________________________ State: _______________ Zip: ____________________

PARTICIPANT AGREEMENT

I hereby authorize the release of records, medical and/or other information necessary to carry out treatment, payment, and other healthcare operations.

Signature: ____ Date: ______/_______/_______