PATIENT REGISTRATION FORM

Name _____ Today's date _____
Last First M.I.

Mailing Address _____ Age _____
Number, Street, Apartment Number

_____
City State Zip

Email address _____Height_____Weight_____

Home Phone (____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Which number would you prefer we use to contact you? _____Home _____Work _____Cell

Date of Birth _____/_____/_____ SS # _____ Marital Status _____ Gender_____

Primary Care Physician	Referring Physician

Preferred Pharmacy: _____City _____

I give permission for Dr. Pillow to access my prescription history and to include it in my medical record. ☐Y_____(initial) ☐N

RACE:

American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Nat Hawaiian/Pacific Islander ☐

Other Race ☐ Unknown ☐ White ☐ Declined ☐

ETHNICITY:

Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Declined ☐

RELIGION:

Buddhist☐ Catholic☐ Hindu☐ Islam☐ Jewish☐ N/A☐ Other☐ Protestant☐ Unknown☐

Employer_____ Retired _____ Full Time Student _____ Part Time Student _____

Spouse's Name: _____Employer _____ Work #_____

Person to notify in case of emergency _____Relationship_____ Phone_____
(Please list a person <u>not</u> living in your home)

When calling in for test results or billing information we will have to determine that you are who you say you are, please answer the following, with something that most people would not know about you.

Security question: _____ Security Answer: _____

May we leave a message on your home/cell answering machine? ☐Y ☐N May we leave a message for you at work to call us? ☐Y ☐N
May we discuss your medical condition with another person? ☐Y ☐N

If yes, whom _____ Relationship _____

How did you hear about our practice? _____