

HEALTHCARE MANDATES REQUIRE ALL PATIENT REGISTRATION INFORMATION FIELDS TO BE COMPLETED:

Date:		
PARENT INFORMATION		
FATHER:		
(Last Name)	(First Name)	(Initial)
Home Address:		
E-Mail:	A A A Walley	
Home Phone:	Cell Phone:	
Employed by:		
Business Address:		
Occupation:	Phone:	
Social Security #:	Date of Birth:	
MOTHER:		(Initial)
(Last Name)	(First Name)	(Initial)
Home Address:		
E-Mail:		
Home Phone:	Cell Phone:	
Employed by:		
Business Address:		
Occupation:	Phone:	
Social Security #:	Date of Birth:	
RESPONSIBLE PARTY INFORMATION		
Who is responsible for this account?		
Address:		
E-Mail:		
Phone:		

PHARMACY INFORMAT	rion			
Which pharmacy do yo	u use?			
Second pharmacy choic	re?			
INSURANCE INFORMAT	TION			
Primary Insurance Nam	e:			
Secondary Insurance Na	ıme:			
		J CHECK IN FOR AN APPOINTM INFORMATION	ENI.	
In order to comply with following questions:	federal regulations regarding	your privacy in or office, we as	k that you o	complete the
May we leave appointme Your answering machine Mobile phone? Mobile phone text? Office Voice Mail? With another person? Through the mail? Via E-Mail? If you answered YES to all	? Yes No	May we leave medical in Your answering machine Cell phone? Mobile phone text? Office Voice Mail? With another person? Through the mail? Via E-Mail? ointment and/or medical informwe may discuss this information	Yes Yes Yes Yes Yes Yes	No
lame		Relationship		
ame		Relationship		
ame		Relationship		

Name		Relationship	······································	
Name		Relationship		
Name	4000	Relationship		
The Art of the State of the Sta		pointment and/or medical information:	ation with	another person,
Vîa E-Mail?	Yes No	VIA E-IVIAII!	163	NO
Through the mail?		Through the mail? Via E-Mail?		No No
With another person?		With another person?		No
	Yes No	Office Voice Mail?		No
Mobile phone text?		Mobile phone text?		_ No
Mobile phone?	FIG. 10.	Cell phone?		No
Your answering machine?		Your answering machine?		
May we leave appointmen	t messages on/with	May we leave medical info	rmation o	n/with
following questions:			•	
In order to comply with fee	N 35 50	<u>! INFORMATION</u> your privacy in or office, we ask ti	hat you co	omplete the
	BB1174 41	/ INCODA & A TION		
PLEASE PRESENT INSURAN	ICE CARD EVERY TIME YOU	J CHECK IN FOR AN APPOINTMEN	<u>II.</u>	
		CUECKINI COD LES CODOS	ı 	
Policy Holder Name:				
Secondary Insurance Name	e:			
rolicy holder Name:				
INSURANCE INFORMATIO				
Second pharmacy choice?				
Which pharmacy do you u	se?			
PHARMACY INFORMATIO				
Table 1				

DEPENDENT INFORMATION:

Patient:			
(Last Name)	(First Name)		(Initial)
Date of Birth:		Male:	Female:
RACE: () White () Black/African American () American Indian/Alaska Native () Asian () Native Hawaiian/Pacific Islander () All Other Races	ETHNICITY: () Hispanic/Latino () Not Hispanic /Latino () Declined to specify/Unkr () None	PRIMARY LA	ANGUAGE:
() Patient declined to specify/Unknown			
Patient: (Last Name)	(First Name)		(Initial)
Date of Birth:		Male:	Female:
RACE: () White () Black/African American () American Indian/Alaska Native () Asian () Native Hawaiian/Pacific Islander () All Other Races () Patient declined to specify/Unknown	ETHNICITY: () Hispanic/Latino () Not Hispanic /Latino () Declined to specify/Unkr () None	PRIMARY LA	ANGUAGE:
Patient: (Last Name)	(First Name)	Majo	(Initial)
Date of Birth: RACE: () White () Black/African American () American Indian/Alaska Native () Asian () Native Hawaiian/Pacific Islander	ETHNICITY: () Hispanic/Latino () Not Hispanic /Latino () Declined to specify/Unki	PRIMARY L	
() All Other Races () Patient declined to specify/Unknown		COUNTRY:	