Patient Registration and Medical History Form

Please print and complete all sections of this form.

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1. Patient Information

Full Name:			
Date of Birth:	MM/DD/YYYY	Gender:	Male/Female/Other
Street Address:			
City:		State & Zip:	
Phone Number:		Email Address:	
Occupation:		Marital Status:	

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2. Emergency Contact Information

Contact Name:		Relationship:	
Phone Number:			

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3. Insurance Information

Insurance Provider:		Subscriber Name:	
Policy Number (ID):		Group Number:	

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4. Medical History

Please list any known allergies (food, drugs, environmental):

Please list current medications and dosages:

Medication 1

Medication 2

Medication 3

Please list past surgeries or major hospitalizations (with approximate dates):

Surgery/Reason & Date

Surgery/Reason & Date

Family Medical History (Please list any major illnesses such as Heart Disease, Diabetes, Cancer):

Do you use tobacco products? (Yes/No, details):

Do you consume alcohol? (Yes/No, frequency):

5. Acknowledgment and Signature

I certify that the information provided above is true and accurate to the best of my knowledge.

Patient/Guardian Signature: Sign here on printed copy

Date: MM/DD/YYYY