☐ Joel Holiner, MD ☐ Rodolfo Molina, MD ☐ Walter Elliston, MD
☐ Robert Freele, MD ☐ Arthur Chavason, MD ☐ Aditya Sharma, MD

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Patient Registration

Date:______________________________ Acct.#:______________________

Patient Name:____
Last First Middle Initial Preferred Name (nickname)

SS#:_______-_______-_______ Gender: ☐ F ☐ M Date of Birth:______/_____/_____ Age:________________

Home Address:____
____
City State Zip Code

Home Phone: (______)_____________________________ Cell phone/Alternate number: (______)_________________________

Email Address: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ White ☐ Black ☐ Hispanic ☐ Native American ☐ Other: __________________

Ethnicity: _________________________________

Employed: ☐ Yes ☐ No Student: ☐ Yes ☐ No

Employer: ____ Occupation:____

Address:____ Wk. Phone: (____)______________________x___________

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Emergency Contact: ____

Phone: (____)____ Relationship to Patient:______________________________

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Referral Source:____________________________________ Specialty:____

Phone: (____)_____________ Address:____

☐ Please check this box if you **DO NOT** want a copy of your evaluation sent to the referral source you have listed above.

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Spouse's Name:____ Spouse's Date of Birth:______/_______/_______
Last First

Spouse's Employer:____

Spouse's Work Phone: (____)__________________________x_____ Spouse's SS#: _________-_______-_____________

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Is Patient a Minor? ☐ Yes ☐ No **IF YES, PARENT / GUARDIAN MUST FILL OUT**

Parent Name:____ Date of Birth: ________/________/____________
Last First

Address: ____ SS#: __________-__________-________________

City: ____________________ State: _______ Zip___________ Home Phone: (____)__________________________

Employer: ____ Work Phone: (____)_________________x________

Relationship to patient: ____________________________________

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May we contact you by phone for appointment reminders? **Home:** ☐ Yes ☐ No **Work:** ☐ Yes ☐ No

____ __________________

Signature of Patient / Parent / Guardian Date

****IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST SIGN****

Pharmacy Information

We must have at least one on file:

Local Pharmacy Name: ____________________________
Phone Number:____________________________________
Address: ____
____
____

Local Pharmacy Name: ____________________________
Phone Number:____________________________________
Address: ____
____
____

Name of Mailorder Company:
____

____ ____________________
Signature of Patient / Parent / Guardian Date

IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST SIGN