Patient Registration Form

Patient information	
Full name:	Date of birth:
Gender: ◯ Male ◯ Female ◯ Other:	
Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed	
Address:	
Phone number:	Email address:
Emergency contact	
Name:	
Relationship to patient:	Phone number:
Insurance information	
Primary insurance:	
Policyholder’s name:	
Policy number:	Group number:
Secondary insurance (if applicable):	
Policyholder’s name:	
Policy number:	Group number:
Primary care physician information	
Physician name:	
Practice/clinic name:	Phone number:
Reason for visit	

Medical history	
Known allergies: ◯ No ◯ Yes, please list:	
Current medications:	
Chronic conditions: ◯ No ◯ Yes, please list:	
Consent	
I, _____, hereby consent to the collection and use of the information provided above for medical purposes and understand that this information will be kept confidential in accordance with applicable laws and regulations.	
Patient’s signature	Date