Patient Registration

This information will be added to your electronic health record. You will be asked to review your contact information once per year. Please let clinic staff know of any changes to your contact information.

Patient Information

Patient First Name: _____ Last Name:_____

Preferred Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

☐ Prefer not to answer

Preferred Pronouns: ☐ she/her/hers ☐ he/him/his

☐they/them/theirs

Address: _____ City: _____ State:_____ Zip:_____

Phone: _____ Email Address:_____

If the patient is unable to sign their own consent form, who is the parent or guardian who will accompany them to appointments and sign for them: _____ Relationship to patient:_____

Our clinic offers discounts for certain populations. Please answer the following questions to determine if you qualify for a discount.

Are you a veteran? ☐ Yes ☐ No

Spouse of a veteran? ☐ Yes ☐ No

Are you over +55? ☐ Yes ☐ No

Are you a Student? ☐ Yes ☐ No

Emergency Contact

Please list one person to contact in case of an emergency situation

Name: _____ Relationship to Patient: _____

Emergency Contact's Phone Number: _____