



Medicare Patient Registration

Name:

_____ Jr. Sr.
First Middle Last

Prefer to be called: _____

Date of Birth: ____/____/____ Sex: F M Social Security: ____/____/____
Month Day Year

Address: _____
Street # Street Name Apt #

_____ City State Zip

Email Address: _____ *(to communicate practice information/events only)

Day Phone: (____)____-____ Evening Phone: (____)____-____

Drivers License Number: _____

How did you learn about our practice? _____

May we leave personal medical information on your Voicemail at home? Yes No

May we e-mail personal medical information to you? Yes No

Do you give our office permission to discuss your medical information with family members?

Yes No If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (____)____ Phone # (evening): (____)____

Name: _____ Relationship: _____

Phone # (day): (____)____ Phone # (evening): (____)____

Emergency Contact Information:

In case of Emergency, whom should we notify? _____

Relationship to Patient: _____ Phone: (____)____

Primary Care Physician: _____ Phone: _____

