PATIENT REGISTRATION

Patient name _____ Sex: M F
Last Middle First
If adult, please select one: Miss Ms Mrs Mr Dr (degree _____) other _____

I/My child like(s) to be called _____ Referred by _____

Patient's Social Security # (optional)_____-_____-_____

Date of Birth _____/_____/_____ Age _____ Occupation _____
Workplace _____

Address
_____
Street Apt
_____
City State Zip

Pharmacy (name/location/ph. number) _____

Legal guardian(s) (if under 18 yrs.)

1) Full Name:
_____
Last Middle First
Relationship to patient _____
Employer/Occupation_____

Social Security (optional) #_____-_____-_____ Date of Birth _____/_____/_____

Address (If different from above)
_____
Street Apt
_____
City State Zip

2) Full Name:
_____
Last Middle First
Relationship to patient _____
Employer/Occupation_____

Social Security (optional) #_____-_____-_____ Date of Birth _____/_____/_____

Address (If different from above)
_____
Street Apt
_____
City State Zip

Main *mailing* address (if different from above)
_____
_____

Contact Numbers (please number in order of preference for communication with the office and INDICATE where it is okay to leave a voice message.)

Home_____ Work_____

Cell _____ Other _____

Emergency contact information Name _____

Relationship _____ Contact phone number _____

Members of Household

Name	Age	Relationship to patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TO WHOM DO WE ADDRESS THE BILL

Responsible Party _____ Date of Birth_____

Mailing Address (street, city, state, zip) _____

Phone Number_____ Relationship to Patient _____

In order to control your cost in billing, it is requested that charges for office visits be paid prior to each visit, unless other arrangements have been made.

Courtesy advance notice:
If your account becomes delinquent it may be referred to an outside collection agency for payment.

I am aware that Dr. Weibrecht's policies, fee schedule and consent forms are subject to change per legal and private practice requirements, and that she will make a good faith effort to notify me 30 days in advance of any changes to this packet or other documents. I have read this document in its entirety and have been given the opportunity to ask questions, as indicated by my signature below.

Guardian/Patient (if 18 and over) Signature _____ Date _____