

## NEW PATIENT REGISTRATION FORM

Registration Date:

| Patient Information |               |                    |          |
|---------------------|---------------|--------------------|----------|
| First Name          | Last Name     | Date of Birth      | Gender   |
|                     |               |                    |          |
| Street Address      | City          | State              | Zip Code |
|                     |               |                    |          |
| Phone Number        | Email Address | Contact Preference |          |
|                     |               |                    |          |

| Emergency Contact Information |               |                         |
|-------------------------------|---------------|-------------------------|
| First Name                    | Last Name     |                         |
|                               |               |                         |
| Phone Number                  | Email Address | Relationship to patient |
|                               |               |                         |

| Medical Information                             |   |
|---|---|
| Do you smoke?                                   | Are you currently taking any medications? |
|   |   |
| If yes, please list all medications and dosages |   |
|   |   |

Signature:

Signature Date: