Patient Registration Form

Last Name	**First Name**	MI	Date
Maiden Name	**Date of Birth**	Age	**Gender**
Race ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American ❒ Hispanic or Latino			
❒ Native Hawaiian or Other Pacific Islander ❒ White ❒ Unknown			
Ethnicity ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Unknown ❒ Decline			
Preferred Language			
Street Address			
City	**State**	**Zip**	
Telephone (Home)	**(Work)**	**(Cell)**	
Email Address	May we contact you by email? ❒ Yes ❒ No		
Where may we leave messages? ❒ Home ❒ Work ❒ Cell			
Where do you prefer to receive your appointment reminder message? ❒ Home ❒ Cell ❒ Email ❒ Text			
Parent(s) / Guardian(s) Name / Healthcare proxy			
Do you have advance directives? ❒ Yes ❒ No			
Marrital Status ❒ Married ❒ Partnership ❒ Separated ❒ Divorced ❒ Widowed ❒ Single			
Live with ❒ Spouse ❒ Partner ❒ Parents ❒ Children ❒ Friends ❒ Alone			
Employment Status ❒ Employed ❒ Unemployed ❒ Full time student ❒ Part time student			
Occupation		Hours per week	
Employer Name and Address			
Emergency Contact	**Relationship**	**Contact Phone**	
Primary Care Physician	Preferred Pharmacy		
How did you hear about Biologic Healthcare?			

***Required fields are indicated in BOLD above**

biologic HEALTHCARE

sensible approaches to your well-being

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