

Patient Registration Form

Last Name *

First Name: *

Date of Birth: *

Age: *

Address Line 1: *

Address Line 2:

City: *

State: *

Zip: *

Cell Phone: *

Home Phone: *

Work Phone: *

Email (required): *

Sex: *

F

M

Other

Current Weight *

Height *

Reason for today's Consultation? *

Marital Status:

Single

Separated

Widowed

Married

Divorced

Occupation:

Employer

City/State

Pharmacy Information

Pharmacy Name: *

Phone #: *

Address: *

How did you hear about us? *

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Current Patient | <input type="checkbox"/> Instagram | <input type="checkbox"/> Event |
| <input type="checkbox"/> Google | <input type="checkbox"/> Family/ Friend | <input type="checkbox"/> Staff Member |
| <input type="checkbox"/> Website | <input type="checkbox"/> Facebook | |
| <input type="checkbox"/> Referral from a Physician | <input type="checkbox"/> Walk In | |

Other or (family/friend name):

Referring Physician (if applicable)

Referring Physician specialty (if applicable)

Primary Care Physician:(If other than referring Physician)

PCP Phone:

Emergency Contact

Name:

Relationship to client:

Best contact #:

Diet: *

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Regular | <input type="checkbox"/> Low Salt | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> No Added Salt | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Low Fat/Cholesterol | <input type="checkbox"/> Low Carb | <input type="checkbox"/> Renal |

Alcohol use?

Yes
 No

Exercise

Sedentary
 Occasional
 Aerobics
 Physically Unable

 Regular
 Active Lifestyle
 Weight Lifting

Advanced Directives:

None
 DNR
 HC Proxy
 Living Will

Recreational Drugs *

Yes
 No

Type:

Tobacco Use?

Yes
 No

Packs/Day:

For how many years have you smoked?

Females Only

	Yes	No
Are you pregnant or considering becoming pregnant in the future?	<input type="radio"/>	<input type="radio"/>
Are you breastfeeding?	<input type="radio"/>	<input type="radio"/>

Number of pregnancies:

Number of deliveries:

Age of children (if applicable):

Birth control method:

Last Pap Smear:

Last Mammogram:

Last Bone Density:

Do you have any of the following conditions:

	Yes	No
Pelvic Pain	<input type="radio"/>	<input type="radio"/>
Uterine Fibroids	<input type="radio"/>	<input type="radio"/>
More painful legs during menstruation	<input type="radio"/>	<input type="radio"/>

Please Read This Form Carefully and Completely Before Signing It

I, , understand that I have a condition that requires medical treatment.

I authorize to determine what kinds of diagnostic procedures (tests) must be done in order to learn more about my condition. These may include electrocardiograms, ultrasounds, blood tests, blood pressure, or other routine tests. I understand that if my doctor advises a more complex test or one which has special risk, it will be explained to me. Further, I authorize the personnel of to assist in giving or to give the tests which my doctor will order.

I also authorize my doctor to determine what kind of treatment is to be given, and to perform such procedures as he/she may deem necessary, in his/her professional judgment, to preserve my health. Additionally, I authorize the personnel of to assist in giving the treatment which my doctor will order. I fully understand that medical tests or treatments may involve certain unavoidable risks.

If part of my treatment is very complex or carries special risks, it will be explained to me.

I understand that it is not practical to list every aspect of medical care, nor every procedure or treatment which I might receive. However, I acknowledge that my doctor is available to answer my questions I might have. I understand that the practice of medicine and surgery are not exact sciences, and acknowledge that no guarantee or assurance has been made to me as a result of treatments or examination.

I certify that I have read this form, and had it explained to me, and certify that I fully understand its contents.

05/22/2025 *

Tap here to sign

Financial Responsibility Agreement

THE UNDERSIGNED agrees whether he/she signs as parent, spouse, guarantor, guardian, or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, I authorize attorney to obtain my credit report: and the undersigned shall pay reasonable attorney's fees and collection expenses.

05/22/2025 *

Tap here to sign