THE CENTER FOR FAMILY MEDICINE, WELLNESS AND AESTHETICS P.A.
PATIENT REGISTRATION

Date: _____

PATIENT INFORMATION:

Dr. Lic #: _____ Date of Birth: _____ Referred By: _____

Social Security Number: ____-___-____ Marital Status: _____ Email Address: _____

Patient Name: _____ M F
(Last) (First) (Middle) (Circle One)

Street Address: _____ Apt. # _____

Mailing Address: _____ Apt. # _____
(if different from above)

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

Leave a Message: _____ (Yes or No)

Parent/Guardian Information

Parent/Guardian Name: _____ Relationship to patient: _____

Address: _____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

(If patient is over 18, parent/guardian must have the patient sign a medical records release to obtain clinical information)

Insurance Information

Primary Insurance Name: _____ Phone Number: (___)_____

Insurance Address: _____

Subscriber Name: _____ Date of Birth : _____

Subscriber ID: _____ Group Number: _____

Employer Information

Employer Name: _____ Phone Number: (___)_____

Address: _____

Emergency Contact Name: _____ Phone Number: (___)_____

Pharmacy Name: _____ Pharmacy Fax Number: (___)_____

The Center for Family Medicine, Wellness & Aesthetics requires patients to call and cancel a scheduled appointment as soon as possible. We prefer to hear from you within 24 hrs prior to the appointment if you need to cancel or reschedule appointment. Several no-showed appointments will result in patients being terminated from The Center for Family Medicine, Wellness and Aesthetics.

I acknowledge prior receipt of Notice of privacy Practices and that no warranty or guarantee has been made to me as to result or cure. I certify that I understand this statement.

Signature_____ **Date**_____

PAYMENT IN FULL IS REQUIRED AT THE TIME OF YOUR VISIT