

PATIENT REGISTRATION

Please make every effort to fill out the following information correctly. This information is held confidentially.

*** PLEASE PRINT ***

Mr. Ms. Mrs. Dr.

Name _____

Date of birth _____ Age _____ Sex _____

SS# _____

Home address _____

City _____ State _____ Zip _____

Telephone Home (____) _____

Work (____) _____

Cell (____) _____

Single () Married () Divorced () Widow ()

Where employed _____

Occupation _____

Doctor you wish to see _____ No preference _____

Insurance Information

Name of health insurance company: _____

Name on insurance card: _____

Group #: _____

Policy/ID #: _____

Employer of card holder: _____

May we contact you by e-mail? If yes, e-mail address _____

Procedures(s) you are contemplating: _____

Why did you select the Straith Clinic? Check all that apply.

() General reputation or recommendation? _____

() Patient referral? If so, patient's name _____

() Seminar? When? _____

() Magazine? Which? _____

() Newspaper? Which? _____

() Yellow Pages? If yes, did you have prior knowledge of the Straith Clinic? () yes () no

() Television ad? _____

() Internet? If yes, did you have prior knowledge of the Straith Clinic? () yes () no

() Other? Please specify _____

NOTE: Patient records are maintained for the required period of ten years. If you desire copies of your records, they must be requested in writing prior to that time frame.

Taping of all consultations is strictly forbidden without prior written consent of the patient, doctor, and/or employee. Please acknowledge by signing _____

patient (if minor, parent/legal guardian)