

## WELCOME TO MY OFFICE

### Patient Registration

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone \_\_\_\_\_

Age: \_\_\_\_\_ S.S. Number: \_\_\_\_\_ Marital Status:  Single  Married  Separated  Divorced

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Spouse's Name (or parent if patient is under 18): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ S.S. Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employed By: \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Do you have any impairment (i.e., visual, hearing, speech, learning, physical and/or language/cultural barrier)?

Yes  No If Yes, please explain: \_\_\_\_\_

What language do you speak, read or write?

Please describe here if applicable: \_\_\_\_\_

Do you have any religious or cultural customs that the doctor should know about?

Yes  No If Yes, please explain: \_\_\_\_\_

Do you have a "Living Will" or "Advance Directive?"  Yes  No

