

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ E-Mail Address: _____

Daytime Phone: _____ Evening Phone: _____

Emergency Contact Name & Phone Number: _____

Primary Care Physician's Name: _____

Primary Care Physician's Address: _____

Primary Care Physician's Phone Number: _____

How did you hear about us? _____

I understand that Dr. Thomas is not a Medicare provider, and does not accept third-party payment. I understand that I am responsible for all charges for services rendered, and that full payment is due at the time of service.

Patient Signature

Date

FOR OFFICE USE ONLY

Viewed website or read brochure

Medical History Form given to complete

Informed Consent given to read

Consultation completed (Date: _____)

Notes: _____

Physician Signature

Date