Patient Registration

Please Print - Fill In All Blanks

Personal Data

Last Name First Name Middle

Address City State Zip

Home Phone ( ) Work Phone ( ) Cell Phone ( )

Please specify best contact number above: ❑ Home ❑ Work ❑ Cell

Birthdate / / Age

Employer Occupation

Marital Status ❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Separated ❑ Divorced

Person to contact in case of an emergency? Emergency Phone ( )

Method of Payment

❑ I am responsible for payment of services

❑ I am a minor and the individual below is responsible for payment of services

Responsible Party Relationship to Patient

Address City State Zip

Home Phone ( ) Work Phone ( ) Cell Phone ( )

Communications

Email Address:

I am interested in having communications sent to me via email (i.e., appointment reminders, newsletters, etc.) ❑ Yes ❑ No

Do you have any specific privacy requests regarding phone calls, emails, or postal mailings?

Referred By

❑ Physician (Name) ❑ Patient/Friend (Name)

❑ Website ❑ Other (Please Specify)

I understand that as a recipient of medical services I, the undersigned, am responsible for all charges and agree to pay in full as requested by the Larrabee Center.

Signature (Patient) X_____ **Date** _____