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

☐ Viewed PowerPoint presentation

☐ Informed Consent given to read

☐ Medical History Form given to complete

☐ Order given for initial lab work

☐ Informed of lab results (Date: _____________)

Notes: ____

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____ Physician Signature

_________________________ Date

Complete Wellness Medical Center
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