681 Douglas Ave Suite 109 Altamonte Springs Fl, 32714

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Patient Registration

Name: _____________________________________ DOB: ____/____/______

Social Security Number: ______________________

Current Address: ____

Phone: _____________________ Alt. Phone: _______________________

Email: ____

Pharmacy and Address: ____

Current Medications: ____

Allergies: ____

Please list the family members or persons we may speak to regarding your general medical condition and your diagnosis (including treatment, payment and health care options).

____________________________ ____

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Please list the family members or persons we may inform about your medical condition ONLY IN AN EMERGENCY.

Name: ____________________________ Phone # ____________________________

Please list the address where you would like any correspondence from our office to be sent if other than your home.

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Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL". ☐ Yes ☐No Please list the telephone number where you want to receive calls about your appointments, labs, results or health care information if other than your home phone number. ____

May we leave a message on your answering machine regarding your results, appointments or other health care information? ☐ Yes ☐No Please be aware a cell phone is not a secure and/or private line.

X Patient Signature: ______________________________________ **Date:** _________________