PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security #:	Home phone #: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone #: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. [illegible] I understand that I am financially responsible for any balance(s). I also authorize Wynn Family Medicine PLLC., or insurance company to release any information required to process my claims.

Patient/Guardian Signature _Date_

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