



THE ENDOCRINE CLINIC, P.C.

PLEASE PRINT

PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME		FIRST	MIDDLE	GENDER M / F	RACE	AGE	DATE OF BIRTH	SOCIAL SECURITY NO.	
STREET ADDRESS			CITY	STATE	ZIP CODE	HOME TELEPHONE NO.		MARITAL STATUS S M W SEP D	
OCCUPATION		NAME OF EMPLOYER			EMPLOYER'S STREET ADDRESS				
CITY		STATE	ZIP CODE	TELEPHONE NO. (WORK)		CELL PHONE			
EMERGENCY CONTACT:				NAME		RELATIONSHIP		PHONE NO.	

PARENT/GUARDIAN INFORMATION (IF STUDENT OR MINOR)

LAST NAME (MOTHER)		FIRST	MIDDLE	AGE	DATE OF BIRTH	SOCIAL SECURITY NO.			
STREET ADDRESS			CITY	STATE	ZIP CODE	TELEPHONE NO. (HOME)		TELEPHONE NO. (WORK)	
LAST NAME (FATHER)		FIRST	MIDDLE	AGE	DATE OF BIRTH	SOCIAL SECURITY NO.			
STREET ADDRESS			CITY	STATE	ZIP CODE	TELEPHONE NO. (HOME)		TELEPHONE NO. (WORK)	

INSURANCE

1. PRIMARY INSURANCE COMPANY NAME _____ I.D. # _____ GROUP # _____
 CLAIMS ADDRESS _____ CITY _____ STATE _____ ZIP _____
 SUBSCRIBERS NAME _____ D.O.B. _____ SS # _____
 EMPLOYER _____ INSURANCE CO. PHONE # _____

2. SECONDARY INSURANCE COMPANY NAME _____ I.D. # _____ GROUP # _____
 CLAIMS ADDRESS _____ CITY _____ STATE _____ ZIP _____
 SUBSCRIBERS NAME _____ D.O.B. _____ SS # _____
 EMPLOYER _____ INSURANCE CO. PHONE # _____

PRIMARY PHYSICIAN _____ DOCTOR/HOSPITAL _____
1 ADDRESS _____ **3** ADDRESS _____
 PHONE NO. _____ PHONE NO. _____

REFERRAL PHYSICIAN _____ PREFERRED HOSPITAL _____
2 ADDRESS _____ **4** ADDRESS _____
 PHONE NO. _____ PHONE NO. _____

RELEASE OF INFORMATION AUTHORIZATION

I authorize The Endocrine Clinic, P.C., to obtain and release past, present, and future medical records to assist in my medical care.

Date: _____ Signature: _____

Relationship if not patient: _____

To contact you regarding pathology or laboratory results:

Do we have permission to leave a message on your answering machine? Yes No
 Do we have permission to leave a message with a family member? Yes No If yes, name of family member _____
 May we call you at work? Yes No
 May we call your cellular number? Yes No

Signed: _____ Date: _____

I authorize payment of medical benefits to the physician or supplier for services described.

Date: _____ Signature: _____