Barrett Clinic P.C.
PRIMARY & PREVENTATIVE HEALTHCARE

Patient Registration **Today's Date: _____**

First Name: _____ MI: ____ Last Name: _____

Nickname: _____ Suffix: _____ Sex: ☐ Female ☐ Male

Address: _____

City:_____ ST:_____ Zip: _____ SSN: _____-_____-_____

Date of Birth: _____ Marital Status: _____

Email: _____ **Yes** **No**

Home Phone: (____)_____ May we leave a detailed message: ☐ ☐

Cell Phone: (____)_____ May we leave a detailed message: ☐ ☐

Consent to call/text: ☐ ☐

Work Phone: (____)_____ May we leave a detailed message: ☐ ☐

Employer: _____ Employer Address: _____

Emergency Contact: _____ Phone: (_____)_____

Relationship to Patient: _____

Preferred Pharmacy: _____ Location: _____ Phone: (___)_____

How did you hear about Barrett Clinic? _____

Do you give Barrett Clinic permission to speak to anyone else about your healthcare? ☐ No

☐ Yes, list name and relationship: _____

Primary Insurance: _____

Policy Holder Name: _____ Date of Birth: _____

Address of Policy holder:_____ City: _____ St: _____ Zip: _____

Phone: (_____)_____

Employer: _____ Relationship to patient: _____

Secondary Insurance: _____

Policy Holder Name: _____ Date of Birth: _____

Address of Policy holder:_____ City: _____ St: _____ Zip: _____

Phone: (_____)_____

Employer: _____ Relationship to patient: _____