



EAST
 1902 East Gore Blvd.
 Lawton, OK 73501

WEST 20
 NW 67th St, Ste E Lawton,
 OK 73501

PATIENT REGISTRATION

Today's complaint: _____

Visit Date: _____

Patient	Last Name: _____		First Name: _____		Middle: _____	
	Address: _____					
	City: _____		State: _____		Zip: _____	
	Home Phone: _____		Work Phone: _____		Cell Phone: _____	
	Preferred Message Phone: _____				SSN: _____ / _____ / _____	
	Date of Birth: _____ / _____ / _____		Age: _____		Marital Status: _____ Sex: _____	
	Employer: _____					
	Employer address/phone: _____					
Email Address: _____						
Would you like us to send informational emails? Y N						

RACE	American Indian or Alaska _____		Asian _____		White _____	
	Black or African American _____		Hawaiian or Pacific Islander _____		Hispanic or Latino _____	
	Not Hispanic or Latino _____					
	Preferred Language _____					
Need Translation Y N						

Health Insurance	Primary Insurance: _____		Effective Date: _____ / _____ / _____	
	Group Number: _____		Subscriber Number: _____	
	Policy Holder Name: _____		Date of Birth: _____	
	Employer: _____		Relationship to Patient: _____	
	Insured SSN: _____			
	Secondary Insurance: _____		Effective Date: _____ / _____ / _____	
	Group Number: _____		Subscriber Number: _____	
	Policy Holder Name: _____		Date of Birth: _____ / _____ / _____	
Employer: _____		Relationship to Patient: _____		

Responsible Party	Last Name: _____		First Name: _____		Middle: _____	
	Address: _____					
	City: _____		State: _____		Zip: _____	
	Home Phone: _____		Work Phone: _____		Cell Phone: _____	
	Preferred Message Phone: _____				SSN: _____ / _____ / _____	
	Date of Birth: _____ / _____ / _____		Marital Status: _____		Sex: _____	
	Employer: _____		Relationship to Patient: _____		_____	
	Employer address/phone: _____					

In Case of Emergency	Last Name: _____		First Name: _____	
	Address: _____		City/State: _____ Zip: _____	
	Relationship to Patient: _____		Phone Number: _____	

Primary Physician	Personal Physician: _____		Phone Number: _____	
	Referred by: _____			

How did you hear about us? ___Newspaper ___Friend/Co-worker ___Internet ___Yellow Pages ___Doctor ___Billboard

Patient Health History Page 2

Medications and dosages: (including over the counter)	Medication Allergies:
1	
2	
3	
4	
5	
6	Hospitalizations/Surgeries:
7	
8	
Medical History/Injuries	

Immunizations: When did you last have?

Tetanus: _____

Flu: _____

Hep B: _____

IMMEDIATE Family History

(Check items that only apply to your IMMEDIATE family history)

Heart Failure (Weak Heart):			Thyroid Disease:	
High Blood Pressure (Hypertension):			Glaucoma:	
Heart Attack or Angina:			Osteoporosis:	
Stroke:			Migraine Headaches:	
High Cholesterol:			Depression:	
Diabetes:			Cancer:	
Emphysema:			Alcoholism:	
Asthma:			Trouble with blood not clotting:	

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary for payment and to obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf and I assign benefits to which I am entitled to this practice. ***I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE AND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE.*** In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. Photocopy of this agreement shall be as valid as the original.

SIGNATURE

DATE