Barnes & Klatt, P.C.

REGISTRATION FORM

Date _____/_____/_____

Patient Name _____

OKAY TO LEAVE A MESSAGE(Circle)

Date of Birth_____/_____/_____ Age_____ Home Phone_____Yes or No

Address _____ Cell Phone _____Yes or No

City, State _____ Zip _____ Work Phone _____Yes or No

Sex: M_____ F _____ Student: F/T _____ P/T ____ Employer _____

Marital Status (Single, Married, Divorced)_____

Spouse's Name _____ Spouse's Cell Phone_____Yes or No

Spouse's Employer_____ Spouse's Work Phone _____ Yes or No

If Patient is a Minor **(under the age of 18)**

Parent/Guardian Name _____ Home Phone _____

Cell Phone_____

Employer _____ Work Phone_____

Parent/Guardian Name _____ Home Phone_____

Cell Phone_____

Employer _____ Work Phone _____

EMERGENCY INFORMATION

In case of emergency, notify _____

Relationship_____ Phone _____

Family Physician _____ Physician's Phone _____

Whom may we thank for referring you to us _____ Phone _____

Office Use Only Account Number _____ Diagnosis _____

Provider _____