

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# _____ Yes or No

Spouse's Work# _____ Yes or No

Email Address: _____ (For Minors Provide Family/Adult/Guardian email)

My email may be used for receiving practice updates and services. Yes ____ 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 _____