Patient Registration

Have you previously been seen here? Yes No If yes, by whom? _____

Which Dr. do you wish to see? Dr. Whightsel **(Gyne only)** Dr. Haller Dr. Nelson Dr. Dust Dr. McDaid Midwife Sara **(OB only)**

If this Doctor is unable to accept you as a new patient, would you wish to consider any of the remaining physicians? ❑ Yes ❑ No

Preferred Day and Time for Appointment or First Available? _____

Reason for appointment:_____Who is your Primary Care/Family Physician? _____

Are you pregnant? ❑ Yes ❑ No Last menstrual period: _____Date of Birth: _____Social Security: _____

Patients Full Name: _____ Maiden Name: _____

Address: _____ City: _____ Zip:_____

Home Phone:_____Cell Phone:_____Phone # where you can be reached during office hours:_____

Leave Messages on voice mail: ❑ Yes ❑ No ❑ Appointments ❑ Billing ❑ Test Results
Leave Message with another person: ❑ Yes ❑ No ❑ Appointments ❑ Billing ❑ Test Results

Email: _____Are you covered by Medicare? ❑Yes ❑No Are you covered by Medicaid? ❑Yes ❑No

Primary Insurance Coverage (attach copy of card)

_____

Secondary Insurance Coverage (attach copy of card)

_____

How did you hear about our practice?_____Referred by: _____