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 Dr. Massengill

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

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

Send/receive secure text messages ❑ Yes ❑ No Preferred Pharmacy _____

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: _____