PATIENT REGISTRATION

Patient's Name: _____
(First) (Middle) (Last)

Address: _____
(City) (State) (Zip)

Preferred Phone (check one): Home _____ Cell _____ Phone #_____

Preferred Method of contact (check one): Phone _____ Email _____ (Checking email will require being on the Follow My Health patient portal)

Email Address: _____

Date of Birth: _____ Gender: M _____ F _____ Social Security # _____

Marital Status (check one): Married _____ Single _____ Widowed _____ Divorced _____

Name of Employer: _____ Work Phone #: _____

Employer's Address: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about our clinic?: _____

Authorization to Discuss Health Information: I hereby authorize medical providers and personnel of Northwest Family Clinics to discuss my protected health information with the named individual(s) below. By leaving this area blank, providers and personnel will not share my protected health information.

Relationship	**Name**	**Phone #**
_____	_____	_____
_____	_____	_____

SIGNATURE_____ **DATE:** _____