Physical and Aesthetic Medicine

Phone: 419-516-0515 **NEW PATIENT REGISTRATION** Fax: 419-228-4620

(Please Print)

Patient Name _____

□ Male □ Female □ Other

Marital Status

□ S □M □W

□ D □ SEP □ Other

Date of Birth / /

Age

Social Security #

Ethnic Group

Hispanic/Latino

□ Yes □ No

Race

□ White □ Black/African American

□ Asian □ Multiracial □ Other

Preferred Language

□ English

□ Spanish □ Other

_____

Patient Street Address **City and State** **Zip Code**

(____)_____(____)_____

Home Phone **Cell Phone**

_____

Email Address (please provide even if you do not use as it counts toward Government requirement for physicians)

_____

Preferred Pharmacy Name **Location**

_____

Spouse Name

TELEPHONE (CELL PHONE) CONSUMER PROTECTION ACT AUTHORIZATION

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated message, email, test messaging, or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Date: _____ Signature: _____