

Patient Registration 2021

Lori McAuliffe, M.D., P.A.

Patient Name: _____ Relationship to Guarantor: _____

Date of Birth: _____ Sex: Male ___ Female ___

Home Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____ Circle: Home Cell Work

Preferred Phone # FOR TEXT REMINDERS: _____ Circle: Iphone Android

E-Mail Address: _____ Preferred Pharmacy #: _____

Referred by: _____

Siblings:	Name	Sex	Date of Birth

Father's/Mother's Name: _____ **Date of Birth:** _____

Home Address (if different): _____

Cell Phone: () _____ Work Phone: () _____

Employer: _____ Are you on the same health insurance plan as your child? _____

Occupation: _____ Email: _____

Marital Status: _____

Mother's/Father's Name: _____ **Date of Birth:** _____

Home Address (if different): _____

Cell Phone: () _____ Work Phone: () _____

Employer: _____ Are you on the same health insurance plan as your child? _____

Occupation: _____ Email: _____

Marital Status: _____

In the event of any emergency* and in your absence, who, other than the parents, has your permission to bring the child to care and may be contacted regarding your child:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Parent Signature*: _____ **Witness Signature:** _____

Date: _____ Date: _____

*This allows me to give my verbal permission to add additional emergency contacts to the above list as needed

Office Use Only:

Received: ___ Copy of Driver's License ___ Copy of Insurance Card

Accepted by: ___ C.Z. ___ E.T. ___ P.N. ___ L.I. ___ A.C. ___ B.H. ___ M.M. ___ N.S.