

Patient Registration 2023

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

Patient Name: _____ **Relationship to Guarantor:** _____
Date of Birth: _____ **Sex:** Male Female **Race:** _____ Hispanic or NonHispanic

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: ___ CZ ___ ET ___ PN ___ LI ___ AC ___ MM ___ CP ___ TM ___ LD 11/2022