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**

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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**