Arrival Time: ______________________

Scheduled Time: ______________________

Clinic Quick Registration Form

Patient Name: ____ **(Marital Status-Circle): M or S**

Date of Birth: ____________________**SSN:** _______________________________

Address:_______________________________**City/State:**____________________**Zip:**_______________

Primary Phone#: _____________________**Secondary Phone# (Optional):**_________________________

Email: ____

Reason for visit: ____

Are you pregnant? **YES** **or** **NO**

Choose all that applies to you:

NEVER SMOKED	FORMER SMOKER	DAILY SMOKER	SOMETIMES SMOKER
NEVER CHEWED TOBACCO	FORMERLY CHEWED TOBACCO	CHEWS TOBACCO DAILY	CHEWS TOBACCO SOMETIMES

Insurance: ____________________________ **Pharmacy:** ______________________________

Emergency Contact:

Name_____________________________________

Phone: ___________________________________

Relationship: _______________________________

Date of Birth: _______________________________

Guarantor Information: for minors under age 18

Name: __________________________________ **DOB:** ____________________________

Phone: __________________________________ **SSN:** ____________________________

Date: _____________ **Clerk's Signature:**___________________________________