Family First Health Center

Delicia M. Haynes, M.D.

REGISTRATION FORM TODAY'S DATE __/____/_____

PLEASE PRINT

Patient's Full Name_____ Age _____

Patient's Social Security # _____ Date of birth _____ Sex _____

Marital Status (circle one) Minor Single Married Widowed Divorced Separated

Home Address _____

Street City State Zip

Home Telephone _____ Cell Phone _____

Patient's Occupation _____ Patient's employer _____

Patient's Employer Address _____ Phone_____

Name of Spouse _____ Spouse's Employer_____ Phone_____

Name of Relative or Friend not living with patient _____phone_____

If patient is a MINOR, fill in responsible parent or guardian:

Mother's Name_____ Mother's Employer _____

Mother's Date of Birth _____ Social Security # _____ Work Phone _____

Father's Name _____ Father's Employer_____

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Father's Date of Birth _____ Social Security #_____ Work Phone _____

Father's Address _____

Have you or anyone in your family been a patient of the doctor? YES NO

Who? _____ Relationship _____

Whom may we thank for referring you to our office? _____

Email Address: _____

Please allow us to photocopy your insurance card(s)

Dissemination of Medical Information:

To whom may we, as your health care provider(s), release information about your medical condition(s)?

_____ _____

Relationship

_____ _____

Relationship

_____ _____

Relationship

_____ _____

Relationship

Family First Health Center

Delicia M. Haynes, M.D.

_____ _____

Signature of Patient or Responsible Party Date Signed

I, the undersigned, or as the parent or legal guardian of the undersigned authorize Dr. Delicia M. Haynes to render medical treatment to myself or the patient above for whom I am responsible.

Signature: _____ Date: _____

I, the undersigned, confirm that I have read the privacy policy of Dr. Delicia M. Haynes

Dated _____, which is included in this registration packet.

Signature: _____ Date: _____