Patient Registration

Patient Contact Info

Name _____ Called Name _____
First MI Last

Address _____

City _____ State _____ Zip Code _____

Phone No: Cell _____ Home _____ Work _____

(Please circle which number is best to reach you)

Email Address _____

It is ok to contact me via email or to leave phone messages regarding my care at the above numbers:( )

I give Be Well Total Health permission to email me: ( ) Invoices, Receipts, Statements

( ) Clinic Updates

( ) Events/Classes

( ) New Product Info

( ) Patient Newsletters

Patient Personal Info

Date of Birth: _____/_____/_____ Current Age _____ Sex: ( ) Male ( ) Female
M D Y

Marital Status: ( )Single ( )Married ( )Common Law ( )Separated ( )Divorced ( )Widowed

Number of Children _____ Social Security Number _____

How did you discover our office and the professional services we offer? _____

Emergency Contact

Name _____ Relationship_____

Phone No(s): _____

Spouse or Guardian Name _____
First MI Last

Phone No(s): _____ Date of Birth:_____/_____/_____
M D Y

Family Physician Name_____Phone No:_____City_____

Permission to consult as clinically indicated: ( ) Yes ( ) No

Patient Employment

Employer Name_____

Occupation_____Address_____

Phone No_____ No. of hours per day at work:_____

I understand and agree to the following Be Well policies:

- **A consultation, history, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services from Be Well in order to allow a comprehensive approach to health to be utilized.**
- **My case must qualify for care at this clinic as determined by the doctors.**
- **If the doctors' assessment shows that I may respond to their care, my case will be qualified for care (additional service may be recommended and I will be advised of applicable cost).**

_____ _____

Patient or Guardian Signature **Date**