Patient Registration Form

Legal Name:_____ **Nickname**:_____
Last First Middle Initial (if applicable)

DOB:_____/_____/_____ **Soc Sec #:**_____ **Sex:** M ○ or F ○
Mo. Day Year

Permanent Address:_____ **Apt. #**_____

City:_____ **State**: _____ **Zip**:_____

Home Phone: ( )_____ **Cell**: ( )_____ **Work**: ( )_____

E-mail Address:_____ (required for Patient Portal)

Preferred Method of Communication: ☐Home Phone ☐Cell Phone ☐Text Message ☐Email

Ethnicity: ☐Hispanic ☐ Not Hispanic **Primary Language**:_____

Race: ☐White ☐African-American ☐Asian ☐Amer. Indian/Alaskan ☐Pacific Islander ☐Other

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other
Sexual Orientation: ☐Heterosexual ☐Homosexual ☐Bisexual

Pharmacy Information:

Name:_____ Location:_____

Phone: ( )_____

Emergency Contact:

Name:_____ Relation:_____ Phone #: ( )_____

Consent for Treatment

I hereby give my consent to Better Me Healthcare for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient). Treatment may include health screening, diagnosis, medical treatment, laboratory procedures, minor or emergency surgical treatment, and/or mental health and drug and alcohol screening assessment, diagnosis and treatment.

Signature:_____ Date:_____