18+ Patient Registry

Last Name: ___________________________________

First Name: ___________________________________ Middle Initial: __________________________

Date of Birth: _________________________________

Ethnicity: Unknown Hispanic or Latino Not Hispanic or Latino Decline to specify

Race: American Indian or Alaskan Native Asian Black or African-American

Native Hawaiian or Other Pacific Islander White Decline to specify Other race

Street Address: ____

City: ____________________________ State: ______________ ZIP code: _________________________

Primary phone number: _______________________________________

Email Address: ____

Preferred method of contact (please circle one):

Recall Notices:	Text message	Phone call	Email
General Practice Notices:	Text message	Phone call	Email
Portal Notices:	All portal communication will take place through email.		
Appointment Reminders:	Text message	Phone call	Email

Emergency contacts (name and relationship):

1. ____ Phone: ___________________________

2. ____ Phone: ____________________________

NOTICE: If you would like to share your medical health information with a third party, such as a parent, you will need to complete an information disclosure form. Thank you.