GEORGETOWN
Wellness & Weightloss Clinic

PATIENT REGISTRATION FORM

Date: _____ Chart Number: _____

PATIENT INFORMATION

How did you hear about our clinic? _____ Email Address _____

Last Name _____ First Name _____ M Initial _____

Address _____

City/St/Zip _____ Date of Birth _____

Marital Status (circle) Single Partnered Married Separated Divorced Widowed

Age _____ Height _____ Weight _____ SS# _____

Home Phone _____ Cell _____

Employer _____ Work Phone _____

Employment status (circle) Full-time Part-time Retired Self-employed Active Military None

How would you like to be contacted for lab results & appointment reminders? (circle) Cell Ph. Home Ph. Text Email Fax

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Home Phone _____ Mobile Phone _____