Dr Samuel Barr

REGISTRATION FORM

Patient Information **Date**_____

Name:_____ I Prefer to be called_____

Address:_____City:_____State:___Zip_ _____

Phone (_____)_____ Work Phone (_____) _____

Cell Phone (_____)_____

The best time to contact me:_____ on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_____

City/State_____ ☐ FT ☐ PT

Spouse or Parent's Name:_____

Whom may we thank for referring you _____

Person to contact in case of emergency_____
Phone_____

Email Address_____

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: (____)_____

Employer_____ Work Phone (____)_____

SSN#_____