Diabetes Care Center
A Medical Corporation

PATIENT REGISTRATION

PLEASE NOTE:

This is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person except when you have authorized us to do so.

Name:_____ Date: _____

DOB: _____ Age: _____ New Patient: ___ Established: ___

Street Address: _____ City: _____

State: _____ Zip: _____ DL #:_____

Email: _____ ☐ I DECLINE TO PROVIDE

☐ I give Diabetes Care Center permission to email me information on workshops, programs and promotional material regarding health and diabetes. We will never sell or share your email. You may unsubscribe at any time.

Social Security #:_____ Account #: _____

Home Phone: _____ Cell Phone: _____

Work Phone:_____ Fax #: _____

Emergency Contact: _____ Phone Number: _____

Birth Sex: M F Marital Status: S M D W Occupation: _____

Primary Doctor: _____ Referring Doctor: _____

Language: _____ Preferred Pharmacy: _____

Preferred way to contact you for appointment reminders: ☐ Phone: home cell or work ☐ Text ☐ Email

Race: *(circle)*

Decline to specify
American Indian or Native Alaskan
Asian
Black or African American
Native Hawaiian or Pacific Islander
White
Hispanic or Latin
Other:

Ethnicity: *(circle)*

Decline to specify
American Indian or Native Alaskan
Asian
Black or African American
Native Hawaiian or Pacific Islander
White
Hispanic or Latin
Other:

I authorize payment of medical benefits be made directly to the physician provider for services rendered. I am financially responsible for all co-payments and non-covered services. I authorize any insurance company, organization, employer, hospital, physician or pharmacist to release any information to this claim and the expenses reported, either by mail, fax or electronically.

Date:_____ Signature (Insured or Authorized): _____