

Patient Registration

Master design review

Please print clearly.

PATIENT INFORMATION

Name

E-mail Address

Height

Weight

MARITAL STATUS

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow ☐ Life Partner

RACE/ORIGIN

☐ African American ☐ Hispanic/Latino ☐ Asian
☐ Caucasian ☐ American Indian ☐ Alaskan Native

TOBACCO

☐ Never Smoked ☐ Former Smoker Stop Date
☐ Smoker How many years How many per day

ALCOHOL

☐ Non Drinker ☐ Social ☐ Beer ☐ Wine ☐ Liquor