

## Harold J. Kaplan, M.D.

### Patient Registration

<input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Mr. <input type="checkbox"/> Dr.	Today's Date:	
Name:	By what name shall we address you? First name/ Last name / Nickname:	
Address:	Contact Date:	
	Chart Number:	
City:	Gender:	
State:                                  Zip:	Birth Date:                                  Age:	
Home Phone: (    )                                  Ext:	Occupation:	
Work Phone: (    )                                  Ext:	Fax: (    )	
Cell Phone: (    )	E-Mail:	
May we call you at home? <input type="checkbox"/> Yes <input type="checkbox"/> No    May we leave a message at home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
May we call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No    May we leave a message at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Best Phone(s) to call: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> No preference		
Best Time(s) to reach you:                                  AM                                  PM		
May we e-mail messages to the address you provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Would you like to receive quarterly e-mail "newsletters"(specials, offers, news)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>REFERRAL SOURCE: Please check the appropriate box(es) and provide details.</b>		
<input type="checkbox"/> Friend _____	<input type="checkbox"/> Relative _____	
<input type="checkbox"/> Physician _____	<input type="checkbox"/> Website _____	
<input type="checkbox"/> Newspaper _____	<input type="checkbox"/> Phone Book _____	
<input type="checkbox"/> Publication _____	<input type="checkbox"/> Other _____	
<b>DRUG ALLERGIES:</b>		
<b>OTHER ALLERGIES:</b>		
<b>EMERGENCY CONTACT:</b>		
<b>Relationship to the patient:</b>		
First name:	Last name:	
Daytime Phone: (    )	Cell Phone: (    )	
<b>OTHER FAMILY MEMBERS WHO HAVE BEEN TO OUR OFFICE:</b>		
Name:	Relationship:	
Name:	Relationship:	
<b>IF PATIENT IS A MINOR:</b>		
Guardian:	Relationship to patient:	
Address:		
Home Phone:	Work Phone:	Cell Phone: