DR. MICHAEL SCOTTO

PATIENT REGISTRATION AND HISTORY

Patient Name: _____ **Phone #:** _____

Address: _____ **Cell Phone#:** _____

City: _____ **State:** _____ **Zip Code:** _____

Sex (circle) **MALE** **FEMALE** **Age:** _____ **Date of Birth:** _____

Occupation: _____

Athletic Activities: _____

Name of Parent (patients under the age of 18): _____

INSURANCE INFORMATION

Insurance Company: _____ **Phone #:**

Member's Name: _____

Insurance ID#: _____ **Member's Date of Birth:** _____

Relationship to Patient (Circle): SELF SPOUSE CHILD

In the case of an emergency, who should be notified? Name: _____

Phone: _____

Please list the name(s) of family members we may discuss/share your medical information with:

_____ _____

Name **Relationship**

_____ _____

Name **Relationship**

May we leave appointment reminders and/or messages on your answering machine/voice mail?

◯ **Yes** ◯ **No**

Would you like to provide your email address for appointment reminders?

Email Address: _____

Primary Care Physician: _____ Pharmacy Name: _____

Pharmacy Address: _____

How did you hear about us? _____ Pharmacy Phone: _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor to administer and perform such procedures upon me as he deems necessary.

_____ Date _____

Signature of Patient, Parent or Guardian

Relationship to Patient: _____

_____

Please print name of Patient, Parent or Guardian