Easy Street Clinic
7202 E Carefree Drive
Carefree, AZ 85377-2872
480-595-0001

PATIENT REGISTRATION FORM

Date: ____________________

PATIENT INFORMATION (Please use full legal name, no nicknames)

Last Name: ______________________________ **First Name:** ________________________ **M.I.** _______

Address: ____

City: ______________________________ **State:** _______________ **Zip:** ______________

Home Phone: (____) - ______ - ________ **Social Security #:** _________________________

Cell Phone: (_____) - ______ - ________

Date of Birth: _________________ **Age:** ______ **Sex:** ______ **Drivers Lic#:** ______________

Employer Name and Address: ____

Email Address: _______________________

Emergency Contact: ___________________________ **Phone:** ________________________

GUARANTOR INFORMATION (List person responsible for payment – use full legal name)

Relationship to Patient: **Self** _______ **Spouse** _______ **Parent** _______ **Other** _______

Last Name: ______________________________ **First Name:** ________________________ **M.I.** _______

Address: ____

City: ______________________________ **State:** _______________ **Zip:** ______________

Home Phone: (____) - ______ - ________ **Social Security #:** _________________________

Cell Phone: (_____) - ______ - ________

Date of Birth: ______________________

INSURANCE INFORMATION (Please allow receptionist to photocopy insurance card and drivers license)

Insurance Company: ______________________________ **Insured's Name:** _________________________

Insured's Date of Birth: ____________________________ **Policy/I.D.:** ______________________________

Easy Street Clinic
7202 East Carefree Dr.
PO Box 2872
Carefree, AZ 85377-2872

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:___________________________ **Last Name**:___________________________

Email address: __________________@__________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ___________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): ___________________

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date: _________________

For office use only

Height: _________ Weight:____________ Blood Pressure:______ /______