The Pelt Clinic (TPC)
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Revised: 4/26/22

The Pelt Clinic PATIENT REGISTRATION FORM:

PERSONAL INFORMATION: * Required			
First Name: *	Middle Initial: *	Last Name: *	
DOB: *	Current Age:	Gender:	Gender Pronoun:
Address: *	City:	State:	Zip Code:
* Cell #:		Alternative #:	
* Email Address:			
Emergency Contact Name:			
Emergency Contact Phone number:			
Relationship to Emergency Contact:			
*** Vaccine Status**	**Response**	**Brand/ Type**	**Date**
* Vaccinated?	YES		
	NO	Reason:	

MEDICAL INFORMATION: * Required			
* Reasons I need treatment:			
* Current Medications:			
* *Medications Allergies:*			
Health Problems:			
PHARMACY Name	***Address***		***Zip Code***
Pharmacy Phone No.		***Pharmacy Fax No.***	

INSURANCE INFORMATION: * Required	
***Primary Insurance Company Name:**	
***MEMBER NAME:**	
***MEMBERS DOB:**	
* Subscribers **EMPLOYER:**	
***DEPENDENT: Yes/No**	
***DEPENDENT DOB:** *(If applicable)*	
***Policy or MEMBER ID Number:**	
Group Number: *(If applicable)*	
Health Plan ID No: (If applicable)	
***Relationship to Subscriber:** *(Self, Spouse, Dependent)*	
Copay Amount (Specialist)	$
REFERRAL SOURCE: How did you find out about this practice?	
Note: All patients will need a **Gmail account** to open an Electronic Health Record (Chart) at The Pelt Clinic, smart phones users will need to download the **Sunwave APP** on **Google Play** or **App Store**.	

Patient Signature: *(Type)* _____

Date: _____