Nelson A. Tajong, M.D.

(Please Print Clearly)

REGISTRATION FORM

Today's date:	Primary Care Doctor:

HAVE YOU HAD THE FLU VACCINE THIS YEAR? YES NO

HAVE YOU EVER HAD THE PNEUMOCOCCAL VACCCINE? YES NO

Pt's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home #: Cell Phone#:

P.O. box:	City:	State:	ZIP Code:

Preferred Language:	Race: (Optional)	Ethnicity:
Email Address:	Occupation:	Employer:
Pharmacy Name:	Pharmacy #: Or Location:	Chose clinic because/Referred to clinic by :

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other ❑Insurance Plan	❑ Dr. ❑ Hospital	

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lakeside gastroenterology or insurance company to release any information required to process my claims.

X

Patient/Guardian signature ***Date***

Please fill out front and back of forms. Thank you