1585 Woodlake Drive, Suite 106 ▪ Town and Country, MO 63017
Phone: (314) 326-4800 ▪ Fax: (314) 266-0558

Adam Fedyk, MD, FACS

## PATIENT REGISTRATION SHEET

☐Dr. ☐Mr. ☐Mrs. ☐Miss ☐Ms. ______________________________ DOB: ____/____/____

Home Phone: ____________________ Cell: ____________________ Work: ____________________

Address: ________________________________________ Apt./Suite: ____________

City: ______________________________ State: __________ Zip Code: ______________

**SSN: (required)** ______________________ Sex: ☐ M ☐ F Marital Status: ☐Single ☐Married ☐Other

Email Address: ____________________________________________

Preferred method of contact: ☐ Home ☐ Cell ☐ Work ☐ Email

If we are unable to reach you, may we leave a message with another person or voicemail? ☐ Yes ☐ No

Preferred Language: ______________________________

Ethnicity:
- ☐ Non-Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Decline to specify

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ White or Caucasian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other
- ☐ Decline to specify

Referred By: ______________________________

Family Physician: ______________________________

Please list all other doctor(s): ____________________________________________

____________________________________________

Patient Employer: ______________________________ Occupation: ____________________

Pharmacy: ____________________ Address and/or Phone Number: ______________________________

**I hereby authorize release of my Protected Health Information for discussion of my care or treatment to the Person(s) specified below. Authorized family member(s) or person(s) to receive verbal information for the above named patient's care.**

| Name: | Relationship: | Phone: |
| --- | --- | --- |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |

**Insurance Information**

Primary Insurance: ____________________________________Subscriber/Relationship to patient: __________________________

Subscriber DOB: _______/_______/_______ Subscriber SSN:_________________________

Secondary Insurance: __________________________________Subscriber/Relationship to patient: __________________________

Subscriber DOB: _______/_______/_______ Subscriber SSN:_________________________

If Patient is a minor, please complete:

Parent/Guardian: ____________________________________________________________ Phone: ____________________________

Address: ____________________________________________________________________________________________________________

E-mail Address:______________________________________________________________