Arthritis & Osteoporosis Associates
Rheumatology At Its Best

Registration Form

Last Name_____ **First Name**_____ **Preferred Name**_____
D.O.B.____/____/_____ **Gender Assigned at Birth:** Male Female **Gender Identity:**_____
Marital Status: S M WID DIV SEP
Address_____ **City**_____ **State**_____ **Zip Code**_____
Home Phone Number:_____ **Cell Phone Number:**_____
Email:_____

I consent to allow a detailed message from the office to be left at provided phone number(s): **YES** **NO**

To comply with federal regulations, we are required to ask you to fill out the following:

Race: White_____ Black/African American_____ Asian_____ Asian Indian_____ Other_____
Ethnicity: Hispanic or Latino YES NO
IF YOU DO NOT WISH TO SHARE THIS INFORMATION: _____Prefer Not to Disclose

I have taken steps to secure a(an): Advanced Directive_____ Living Will_____ Power of Attorney_____
I DO NOT have an Advanced Directive_____

Emergency Contact
Name_____ **Phone Number**_____ **Relationship**_____

Primary Care Provider:_____ **Phone Number**_____
Referring Physician:_____ **Phone Number**_____
Local Pharmacy:_____ **Address**_____ **City**_____
State_____ **Phone Number**_____

Mail Away (Specialty) Pharmacy_____ **Phone Number**_____

I certify that all the information is accurate and acknowledge receipt of the Notice of Privacy Practices. I state that I have read and understand the terms and conditions of the Patient Financial Policy.

Signature_____ **Date**_____