

Elisabeth Potter, MD, PLLC

New Patient Registration Form

Patient Demographics

First Name _____ Middle Name _____ Last Name _____

Preferred Name First Name Middle Name Nickname _____

Address _____ Zip Code _____

Social Security _____ - _____ - _____ Birth Date ____/____/____ Age _____

Marital Status Single Married to _____ Divorced Widowed

Contact Information

Home (____) ____-____ Work (____) ____-____ Mobile (____) ____-____

May we call for appt. reminders? Yes No May we leave a voicemail? Yes No

Email _____ Preferred Contact Home Work Mobile

Emergency Contact

First & Last Name _____ Relationship _____

Home or Mobile Phone (____) ____-____ Work Phone (____) ____-____

May we list your emergency contact as a **HIPAA contact** as well? Yes No

Patient Demographics Continued

Occupation _____ Company/School _____

Company Address _____ Zip Code _____

Primary Language English Other _____ Interpreter Needed Yes No

Referral Source

How did you hear about us? Referral _____

Internet Search _____ Advertisement _____ Other _____

Primary Care Physician

First & Last Name _____ Company/Location _____

You may edit this information at any time through our online patient portal.

www.drpotter.com