Garrett M. Crabtree, M.D.
REGISTRATION FORM

(Please Print)

Today's date:	**Primary Care Physician:**

PATIENT INFORMATION

Last name:	**First name:**	**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?	Social Security#	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address: E-mail address:	Insurance subscriber's DOB:	Home phone # Cell phone #

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

Occupation:	Employer:	Employer phone no.: ( )

Referred to Dr. Crabtree by: (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital	❑ Family

❑ Friend	❑ Close to home/work	❑ Internet	❑ Yellow Pages	❑ Other

Other family members seen here:

MEDICAL INFORMATION

List all current medications:_____

_____

_____

List all medication Allergies:_____

Do you have any medical problems:_____

_____

List major surgeries/illnesses:_____

_____

Any history of melanoma or other skin cancer in your family:_____

Are you pregnant:_____ Do you smoke:_____

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #:	Work phone #: