REGISTRATION FORM
ADULT, AGE 18 AND OLDER

ROOTS WELLCARE, P.A.

Patient Name____ Date______________________________

Address____
Street/Apt No. City/State Zip

Phone____
Home Work

____
Cell Pager

Email____@____

Date of Birth____________________________ Age______________ Sex_________________________

If you wish to say more about gender identity and/or preferred pronoun, please discuss with Dr. Breunig.

Marital status: single married divorced widowed separated partnered
(circle)

Education (years completed) Elem____ HS____ College____ Vocational____ Professional____

Number of children_________________ Their ages____

Occupation or Nature of your work____

Retired or semi-retired?____

Employer____ Address__________________________________

Spouse/Partner's Name___________________________ Work Phone________________________________

Emergency Contact______________________________ Phone_____________________________________
(person other than spouse/partner)

Family Physician/Clinic___________________________ Phone_____________________________________

Whom may we thank for referring you?____