Hatteras Island Family Medicine
Patient Registration

(Please Print)

Please answer all questions completely.

Patient Information

_____ Jr / Sr /III ____/____/____
Last Name First Name M.I. Date of Birth

_____ _____ - _____ - _____
Male or Female Social Security Number

_____
PO Box Physical Address City State Zip Code

_____ _____ _____ _____ _____
Partner Name Single Married Divorced Widowed

(____) _____ _____ _____
Home Phone E-mail Address Employer/School Name

(____) _____ (____) _____
Cell Phone Work Phone

_____
How did you hear about Hatteras Island Family Medicine?

In Case of Emergency

(____) _____ _____
Emergency Phone Number Emergency Contact Name and Relationship to patient

Parent Information (if patient is under 18 years of age)

_____
Last Name First Name M.I.

_____
Mailing Address

(____) _____ (____) _____ _____
Home Phone Cell Phone E-mail Address