1585 Woodlake Drive, Suite 106 ▪ Town and Country, MO 63017
Phone: (314) 326-4800 ▪ Fax: (314) 266-0558

Adam Fedyk, MD, FACS

PATIENT REGISTRATION SHEET

☐Dr. ☐Mr. ☐Mrs. ☐Miss ☐Ms. ______________________________ DOB: _____/_____/_____

Home Phone: ____________________ Cell: ____________________ Work: ____________________

Address: ____ Apt./Suite: ______________

City: ____________________________ State: __________ Zip Code: ______________

SSN: (required) ______________________ Sex: ☐ M ☐ F Marital Status: ☐Single ☐Married ☐Other

Email Address: ____

Preferred method of contact: ☐ Home ☐ Cell ☐ Work ☐ Email

If we are unable to reach you, may we leave a message with another person or voicemail? ☐ Yes ☐ No

Preferred Language: ______________________________

Ethnicity:
- ☐ Non-Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Decline to specify

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ White or Caucasian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other
- ☐ Decline to specify

Referred By: ______________________________

Family Physician: ______________________________

Please list all other doctor(s): ______________________________

____

Patient Employer: ______________________________ Occupation: ______________

Pharmacy: ____________________ Address and/or Phone Number: ______________________

I hereby authorize release of my Protected Health Information for discussion of my care or treatment to the Person(s) specified below. Authorized family member(s) or person(s) to receive verbal information for the above named patient's care.

Name:	Relationship:	Phone:

Insurance Information

Primary Insurance: ______________________________________Subscriber/Relationship to patient: ____________________________

Subscriber DOB: ________/________/________ Subscriber SSN:___________________________

Secondary Insurance: _______________________________________Subscriber/Relationship to patient: ___________________________

Subscriber DOB: ________/________/________ Subscriber SSN:___________________________

If Patient is a minor, please complete:

Parent/Guardian: ____ Phone: ______________________________

Address: ____

E-mail Address:____