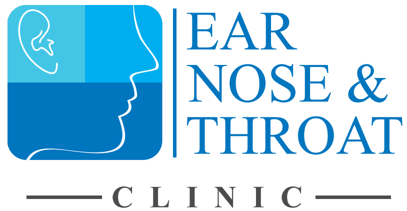

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www.fairbanksent.com

PATIENT REGISTRATION

Patient Name: ____

Address: ____

____

D.O.B:__________________ SS#:______________ Preferred Language: __________________

Ethnicity & Race: ______________________________________

Responsible Party: ___________________________________Relationship________________

Employer______________________________________

Phone# :________________(H)________________(C)_______________(W)

Please Select Preffered Phone # to Contact

If Child Responsible Party or Insurance Subscriber

Name: ____________________________ D.O.B:______________________

SS#:______________________________

Work: ____

Emergency Contact: ______________________________Phone#: ________________________

Drug Allergies: __________________________________ Pharmacy:______________________

________________________ Date: _____/_____/________

Signature