REGISTRATION FORM

Last Name: ______________________________ First: _______________________________ M.I.: _____

DOB: _____ / _____ /_______ Gender: _____ Male _____ Female

Mailing Address: ____ Apt.: ___________

City: ______________________________________ State: ____________ Zip Code: ________________

E-mail: ____

Home Phone: _________________________________ Cell Phone: ____________________________

How did you hear about us?

____

REASON FOR VISIT:

____

Name of employer: ____

If your visit to PrimeStaff Health is not covered by your employer by payment/contract OR third party administrator, you will be required to pay 100% of the office visit. It is your responsibility to determine if you are expected to cover today's visit and services.

______________ Please initial. This indicates that you have read and agree with the statement above.

______________________________	____________________________	___ / ___ / ______
Print Client Name	Signature of Client	Date