Stacy L. Waneka, M.D.
Family & Travel Medicine

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PATIENT REGISTRATION INFORMATION

Please PRINT all sections below

Today's Date _____

Name: _____ Age _____ Date of Birth _____
Last First Middle Initial

If Minor, Parent or Guardian Name: _____

Status: o Single o Married o Divorced o Widowed o Male o Female

Street Address: _____ City: _____

State: _____ Zip: _____

Home Phone:(____) _____ Work Phone:(____) _____

Cell Phone: (____) _____ E-mail address: _____

Social Security #: _____

Employer: _____ Occupation: _____

Spouse Name: _____

Spouse SS#: _____ Spouse DOB: _____

Who else is in your home?

o Mother _____

o Father _____

o Partner _____

o Children _____

Please Present your insurance card(s) to the receptionist to be photocopied.

REFERRAL INFORMATION:	EMERGENCY CONTACT:
Who referred you to us? _____	_____
Names of other physicians who care for you:	Relation: _____
_____	
_____	Phone (home): _____
_____	
_____	Phone (work): _____
_____	