ReforMedicine SC
Direct Pay Family Practice &
Medical Weight Loss Specialists

Innovative, Passionate, Authentic
Transcending the standards to provide affordable, accessible, and exceptional primary care.

New Patient Registration

PLEASE PRINT AND COMPLETE IN FULL

Patient's Legal Name: _____
First **Middle** **Last**

Birthdate: _____ **Gender:** Male_____Female_____
MM/DD/YYYY

Patient's Street Address: __

_____
City **State** **Zip**

Home Phone Number: ____-____-_____ **Cell Phone Number:** ____-____-_____

Work Phone Number: ___-____-_____ **Email Address:** _____
Ext: _____ (for patient portal access)

Parent/Guardian Name (if under 18):_____

Emergency Contact Name:_____**Phone Number:**_____

Relation to Patient:_____

Do you have any allergies? Please list:_____

Preferred Pharmacy:_____

Medications/supplements

Name	Dose	Directions

_____**If you have additional medications please check here and continue the list on the back of the page.**

Please let staff know if you are on Medicare, Medicaid or Badger Care. Thank you.