



Date: _____

Patient Registration Information

Please **PRINT AND COMPLETE ALL** sections below!

Your Email: _____ Auto accident? Yes / NO Date of injury: _____

PATIENT'S PERSONAL INFORMATION Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Name: _____			
Last name		First name initial	
Street address: _____ (Apt# _____) City: _____ State: _____ Zip: _____			
Home phone: (____) _____ Work Phone (____) _____ Social Security# _____ - _____ - _____			
Date of Birth: ____/____/____ Driver's License: (State & Number) _____			
Employer/Name of School _____ Full Time <input type="checkbox"/> Part Time <input type="checkbox"/>			
Address: _____ (Apt# _____) City: _____ State: _____ Zip: _____			
Your occupation: _____			
Spouse's Name: _____ Spouse's Home Phone: (____) _____			
Last name		First name initial	
Spouse's Employer's name: _____ Spouse's Work: (____) _____			
Address: _____ (Apt# _____) City: _____ State: _____ Zip: _____			
How do you wish to be addressed? _____ Social Security# _____ - _____ - _____			
PATIENT'S / RESPONSIBLE PARTY INFORMATION			
Responsible party: _____ Home phone: (____) _____ Date of Birth: ____/____/____			
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ Social Security# _____ - _____ - _____			
Address: _____ City: _____ State: _____ Zip: _____			
PATIENT'S REFERRAL INFORMATION			
Referred by: _____ If referred by a friend, may we thank her or him? YES / NO			
Referred: <input type="checkbox"/> TV <input type="checkbox"/> Website <input type="checkbox"/> N.J. Naturally			
Name(s) of other physicians(s) who care for you: _____			
EMERGENCY CONTACT			
Name of person not living with you: _____ Relationship: _____			
Address: _____ (Apt# _____) City: _____ State: _____ Zip: _____			
Home phone: (____) _____ Work phone: (____) _____			

I, _____, understand that Dr. Sharda Sharma provides consultation services only, and that she is not a primary care physician. Any consultations I have with her are not substitutes for visits with my regular physician. For routine care, urgent care or emergency services, I will contact my primary care physician.

My primary care physician is Dr. _____, whose office is located at _____

And whose office telephone number is (____) _____.

WE DO NOT PARTICIPATE WITH ANY INSURANCE

Patient's Signature