

HEALTHIER TOMORROWS PATIENT REGISTRATION FORM

Please have both sections of this form completed. After this form is completed, please return by:

FAX (631) 425.0140

Patient Information (to be completed by patient's FAMILY)

Name of Patient: _____

Gender: _____ Age: _____

Date of Birth: _____

Address: _____

Phone: (____) _____

Email: _____

Physician Information (to be completed by patient's PRIMARY CARE PHYSICIAN)

Name of physician: _____

Office Address: _____

Office Phone: (____) _____

Office Fax: (____) _____

Date of Patient's Last Physical Exam: _____

Height: _____ Weight: _____ BMI: _____ BMI %: _____

Please list patient's significant chronic medical problems (if any):

Does the patient have any medical contraindications to participate in Healthier Tomorrows?

Yes _____ No _____

Physician Signature: _____