

**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  
OR  
EMAIL: [esullivan@hunthosp.org](mailto:esullivan@hunthosp.org)

**Patient Information** (to be completed by family)

Name of Patient: \_\_\_\_\_

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 \_\_\_\_\_

Have you provided the patient with a prescription to obtain entrance lab tests?

Yes \_\_\_\_\_ No \_\_\_\_\_

Physician Signature: \_\_\_\_\_