Meliora Family Medicine PLLC

REGISTRATION FORM

Patient Name_____ Sex: M__ F__ DOB___/___/____
Last First Middle

Address_____ SSN: _____

City_____ State_____ Zip Code_____

Phone: Home_____ Cell_____ Work _____

Occupation: _____ Employer/School: _____

Work Address: _____

Marital Status: _____ Spouse/Partner's Name: _____

Head of Household / Guarantor (If different from above):

Name_____ Sex: M___F___DOB_____

Relationship to Patient: _____ Phone: _____

Address_____

City_____ State_____ Zip Code_____

Emergency Contact:

Name_____ Relationship: _____

Address_____

City_____ State_____ Zip Code_____

Phone: Home_____ Work_____Cell_____

Do you have an Advanced Directive, Health Care Proxy or Living Will? Yes / No

How did you hear about Dr. Davis? _____

_____ _____
Signature Date

Office Use Only: ***Membership Plan A B C*** ***Account #*** _____

Acupuncture Only ***Account #*** _____

• Jessica Davis MD • (877) 664-6116 • 172 Hudson Avenue, Stillwater, NY 12170 •