960 S 24th St W Unit H
Billings, MT 59102
Ph: 406-272-2376
Fax: 406-645-7995

NEW PATIENT REGISTRATION

Name: ____ Nickname: _______________________

DOB: ____/____/____ SSN #: ______-___-______ Gender: M___F___Other____

Home Address: _______________________________________City,State __________________Zip________

Home phone #: __________________________________

For patients under the age of 18:

School: _______________________________ Current grade: _______ Hobbies/Sports: __________________
Mother's Name: ____ Cell:__________________________
Mother's Occupation: ________________________ Mother's Email: ________________________________
Father's Name: ____ Cell: __________________________
Father's Occupation: _________________________ Father's Email: _________________________________
Siblings (names and ages): ____
Patient lives with: ____

How did you hear about us?____

EMERGENCY CONTACT

Who would you like us to contact in case of an emergency?
Name:_____________________________________ Relationship: ___________

Primary #: (____) ______-________ Home ( ) Cell ( ) Work ( )
Secondary #: (____) ______-________ Home ( ) Cell ( ) Work ( )

PRIMARY CARE, REFERRAL & OTHER INFO

Primary Care Physician: ______________________ Phone: (___) ____-___________

Referring Physician: _________________________ Phone: (___) ____-___________
Are other family members a patient of Dr. Hua's?_________________________

PREFERRED PHARMACY INFORMATION

Pharmacy Name: _______________________Phone: (____) _____-______________

Pharmacy Address:____

***If you require refills, please have your pharmacy fax requests to us directly before you call the office. This will help us get refills to you quicker.