

Body Renew, LLC  
 7581 S. Willow Dr., Tempe, AZ 85283  
 Office : 480-463-4006 Fax : 1-888-828-1207

**REGISTRATION FORM**

*Please Print*

Today's date: ____/____/____					
<b>PATIENT INFORMATION</b>					
Last name:		First:		Nickname:	
Marital status (circle one): Single / Mar / Div / Sep / Wid				<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	
Address:					
City:	State:	Zip:	Birth date: / /	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Additional Address (if needed): Street:			City:	State:	Zip:
Home Phone #:			Mobile #:		
Work #:			Occupation:		
Can you send and receive text messages on your mobile phone? <input type="checkbox"/> Yes <input type="checkbox"/> No					
*Your medical information is confidential and we make every effort to honor that trust. If you can not be personally contacted, at which of the numbers may we leave a message to return our call: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile					
Email:					
How did you hear about us: <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> Website <input type="checkbox"/> Internet search <input type="checkbox"/> Other (please write in):					
Referred to our clinic by:	Name:				
Names of other Physicians & Health Care Providers:	Specialty	Address		Phone number	
Your Pharmacy name:			Phone number:		
Address of Pharmacy (or cross-streets and city):					
*Please note that Body Renew, LLC does not participate in any insurance plans.					
<b>IN CASE OF EMERGENCY</b>					
Name:		Relationship to patient:	Home phone #:	Work/Mobile phone #:	
I certify that the above information is correct. By signing below I confirm that I have read and understand the Notice of Information Practices and Privacy Statement.					
Patient Signature: _____				Date: _____	
Guardian signature (if required): _____				Date: _____	