



Laurie Thomas MD  
*Your Hometown Family Doctor*  
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### Patient Registration

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Patient's DOB \_\_\_\_\_

Address: \_\_\_\_\_ Phone 1: \_\_\_\_\_

\_\_\_\_\_ Phone 2: \_\_\_\_\_

Email: \_\_\_\_\_

How do you prefer us to contact you? \_\_\_\_\_

Allergies to medicines: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Preferred pharmacy: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Address: \_\_\_\_\_

Phone 2: \_\_\_\_\_

I give permission to release medical information to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_