Sugar Doctor

Patient Registration Form

Dr. Brian C. Brill, Jr. D.O.

Please fill out as much as possible.

Patient Name: _____ Date of Birth: ____/____/_____

Address: _____ City: _____

State: _____ ZIP: _____ Sex: ❑ Male ❑ Female

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email: _____

We send appointment reminders through call, text, and email.

Emergency Contact Name: _____

Relation: _____ Phone: (_____) _____ - _____

PCP Name: _____ Referring Physician Name: _____

Pharmacy Name: _____ Pharmacy Location: _____

Primary Insurance: _____ Secondary Insurance: _____

How did you hear about us?

❑ Family / Friend ❑ Radio ❑ Facebook ❑ Other: _____

Select One:

❑ Pre-Diabetic ❑ Type 1 Diabetic ❑ Type 2 Diabetic ❑ Unsure

Print Name: _____

Signature: _____

Date: _____/_____/_____