PATIENT REGISTRATION

Please Complete All Information

For Office Staff Use Only:
Date: ___ / ___ / 20___
BP: _____ / _____ P: _____

Patient Information:

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Preferred Name: _____

Address: _____ **Apt #:** _____

City / State / Zip: _____ / _____ / _____

Home Phone: (____) _____ - _____ **Cell Phone:** (____) _____ - _____ **Work Phone:** (____) _____ - _____ **Ext:** ____

Date of Birth (MM/DD/YYYY): _____ / _____ / _____ **Social Security #:** _____ - ___ - _____

Email: _____ @ _____ . ____

I would like to receive correspondence via email? YES / NO

I would like to receive correspondence via text? YES/NO

Please Circle Correct Choice Below:

Sex: MALE FEMALE **Marital Status:** Married Single Divorced Separated Widowed

Primary Spoken Language: _____ **Preferred Pharmacy:**_____

How did you hear about us? _____

(If someone referred you please write down their name so we can thank them)

Parent/Legal Guardian (if someone other than the patient):

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Preferred Name: _____ **Driver's License #:** _____

Address: _____ **Apt #:** _____

City / State / Zip: _____ / _____ / _____

Home Phone: (____) _____ - _____ **Work Phone:** (____) _____ - _____ **Ext:** ____ **Cell Phone:** (____) _____ - _____

Date of Birth (MM/DD/YYYY): _____ / _____ / _____ **Social Security #:** _____ - ___ - _____

Email: _____ @ _____ . ____

Emergency Contact:

First Name: _____ **Last Name:** _____

Phone: (____) _____ - _____ **Relationship:** _____

Primary Insurance Information:

Name of Insured: _____ **Insured Social Security #:** _____ - ___ - _____

Relationship of Insured: ___ Self / ___ Spouse / ___ Child / ____ Other

Insured Date of Birth (MM/DD/YYYY): _____ / _____ / _____

Employer: _____ **Insurance Company:** _____

Secondary Insurance Information:

Name of Insured: _____ **Insured Social Security #:** _____ - ___ - _____

Relationship of Insured: ___ Self / ___ Spouse / ___ Child / ____ Other

Insured Date of Birth (MM/DD/YYYY): _____ / _____ / _____

Employer: _____ **Insurance Company:** _____