PATIENT REGISTRATION

Please Complete All Information

Patient Information:

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

Preferred Name:_____ Drivers License #:_____

Address:_____

City / State / Zip:_____/_____/_____

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

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

Email: _____@_____._____

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

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Primary Spoken Language: _____ Preferred Pharmacy/ Phone Number: _____

I am the: Policy Holder? YES / NO

How did you hear about us? _____

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

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

First Name:_____ Last Name: _____Middle Initial: _____

Preferred Name: _____ Drivers License #: _____

Address: _____

City / State / Zip: _____/_____/_____

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

Claim Address: _____

City/ State / Zip: _____/_____/_____

Insurance Company Phone Number: (_____) _____-_____

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_____

Claim Address: _____

City/ State / Zip: _____/_____/_____

Insurance Company Phone Number: (_____) _____-_____