

## Patient Registration

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Date \_\_\_\_\_

Patient Name Last : \_\_\_\_\_ First: \_\_\_\_\_ Middle \_\_\_\_\_

Male  Female  Mr  Mrs  Miss  Master

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security \_\_\_\_\_

Race:  White  Black  Other \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Other \_\_\_\_\_

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

Preferred Pharmacy: \_\_\_\_\_

Responsible Party (or guardian) Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

Referred By: Who may we thank for your visit today? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Does your plan require referrals for specialist care?  Yes  No

Primary Insurance: \_\_\_\_\_

Policy # \_\_\_\_\_ Group# / Name \_\_\_\_\_ Copay \$ \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient relationship to policy holder:  Self  Spouse  Child

Secondary Insurance: \_\_\_\_\_

Policy # \_\_\_\_\_ Group# / Name \_\_\_\_\_ Copay \$ \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient relationship to policy holder:  Self  Spouse  Child