Patient Registration Information Date: _____

Patients First Name_____ Middle Initial _____ Last Name _____

How would you like our staff to address you? _____

Date of Birth _____/_____/_____ Age _____ Sex_____

Mailing Address_____ City_____ State____ Zip _____

If different, full street address_____City_____ State_____ Zip _____

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

Best Time to Call _____Email Address _____

SSN _____/_____/_____Marital Status _____

Preferred Language:_____ Race:_____

Ethnicity:_____

Preferred Pharmacy _____ City/State _____

How did you hear about us?_____

PCP/Medical Doctor:_____

Employer_____ Phone ( ) _____ - _____

Full Time, Part Time Occupation or school name_____

Emergency contact name: _____Relationship to Patient_____Phone( )_____-_____

Responsible Party's Name _____ Date of Birth ____ /____ /_____ Age ____ Sex____

If different address from patient, please provide information below.

Address_____ City_____ State_____ Zip _____

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

Employer _____ SSN _____

Full Time/ Part Time Occupation / Retired _____

Primary Insurance _____ Primary Insured name_____

Primary Insured date of birth_____Primary Insured SSN_____

Group #_____ID_____

Secondary Insurance _____ Secondary Insured name_____

Secondary Insured date of birth_____Secondary Insured SSN_____

Group #_____ID_____

Relationship of patient to the policyholder: SELF SPOUSE PARTNER CHILD OTHER (please circle answer)