PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name (Last)_______________ (First)_______________ (MI)_______

Date of Birth ____/____/____ ☐ Female ☐ Male Social Security Number _______________

Phone Numbers Home_______________ Cell _______________ Work_______________

Mailing Address _______________City, State, ZIP _______________

Physical Address (if different from mailing)_______________

E-mail Address _______________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Island ☐ Black/African American ☐ White/Caucasian

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language:_______________

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_______________ Occupation_______________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name_______________ Phone Number_______________

Emergency Contact Relationship to Patient ☐ Mother ☐ Father ☐ Other:_______________

RESPONSIBLE PARTY INFORMATION **If same as patient, proceed to insurance information.**

Responsible Party Name (Last)_______________ (First)_______________ (MI)_______

Date of Birth ____/____/____ ☐ Female ☐ Male Social Security Number ______-______-______

Phone Numbers Home_______________ Cell_______________ Work_______________

Home Address_______________City, State, ZIP _______________

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_______________ Employer Phone Number_______________

Patient Relationship to Responsible Party_______________

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Plan_______________ Subscriber's Name_______________

Patient's relationship to subscriber _______________ Subscriber's SSN _______________ Subscriber's DOB_______________

ID # _______________ Group # _______________ Co-pay _______________

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Plan_______________ Subscriber's Name_______________

Patient's relationship to subscriber _______________ Subscriber's SSN _______________ Subscriber's DOB_______________

ID # _______________ Group # _______________ Co-pay _______________

PREFERRED PHARMACY NAME AND ADDRESS_______________ **Phone:**_______________

*** I attest that the information supplied on this form is accurate and up-to-date to the best of my knowledge.***

Patient (or Responsible Party) Signature_______________ ***Date***_______________