PATIENT REGISTRATION

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_____ **Religion:** Catholic___ Jewish____ 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: Name: _____ Phone #: (___)_____

Relationship to Patient: _____

Does your plan require referrals for specialist care? [ ] Yes [ ] No

Primary Insurance:_____

Policy # _____ Group# / Name _____ Copay $_____

Policyholder Name _____ Social Security # _____-_____-_____

Birth Date _____/_____/_____ Patient relationship to policy holder: [ ] Self [ ] Spouse [ ] Child

Secondary Insurance:_____

Policy # _____ Group# / Name _____ Copay $_____

Policyholder Name _____ Social Security # _____-_____-_____

Birth Date _____/_____/_____ Patient relationship to policy holder: [ ] Self [ ] Spouse [ ] Child

Please turn page over for insurance payment disclosure & signature