Patient Registration

HOW DID YOU HEAR ABOUT US? ______________________________

First Name: _______________________ Last Name: _________________________ Middle Initial: ______

Preferred Name: ________________________ Patient is: ☐ Policy Holder ☐ Financially Responsible Party

Patient Info:

Address: _______________________________________ City: ______________ State/Zip: ___________

Home: ______________ Cell: _______________Work: _______________Ext:________

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

DOB: ____________ Soc Sec: ______-______-_______Drivers Lic #: ____________

E-mail: ________________________________ I would like to receive correspondences via: ☐ E-mail ☐ Text

Financially Responsible Party Info: (if someone other than patient) - Name: ______________________________

Address: _______________________________________ City: ______________ State/Zip: ____________

Home: ______________ Cell: _______________Work: _______________Ext:________

DOB: ____________ Soc Sec: ______-______-_______ Email:__________________________________

Primary Insurance Info:

Name of Policy Holder: _______________________ Relation to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Member ID **OR** Policy Holder SS#: ___________________Group #:____________ Policy Holder's DOB: ________

Employer: ____________________________ | Ins Company: ___________________________

Address: ____________________________ | Address: ___________________________

City, State, Zip: ___________________________ | City, State, Zip: ___________________________

Secondary Insurance Info:

Name of Policy Holder: _______________________ Relation to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Member ID **OR** Policy Holder SS#: ___________________Group #:____________ Policy Holder's DOB: ________

Employer: ____________________________ | Ins Company: ___________________________

Address: ____________________________ | Address: ___________________________

City, State, Zip: ___________________________ | City, State, Zip: ___________________________

Miscellaneous:

Preferred Pharmacy: ____________________________________

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ N/A

Emergency Contact: ______________________________ Phone: __________________ ☐ Cell ☐ Home