PLEASE PRINT CLEARLY

PATIENT REGISTRATION FORM

Please provide your insurance card and picture ID to the receptionist

Today's Date:

Primary Provider: Pharmacy Name/Phone # PBM Yes/No

PATIENT DEMOGRAPHIC INFORMATION

Last Name: First Name: Middle:

Preferred Name: Maiden Name: Prefix (circle one) Suffix (circle one)
Miss Mr. Mrs. Ms. Dr. N/A I II III IV Jr. Sr.

Date of Birth: Sex: Social Security #: Race:

Marital Status: Drivers License # Primary Language:

Religion: Ethnicity: (Circle One)
Decline Hispanic/Latino Not Hispanic/Latino Unknown

Address:

Zip: City: State: County:

Home Phone: Work Phone: Cell Phone: Primary Number:

Is it ok to leave a message at HOME Y____N_____ WORK Y____N_____ CELL Y____N____

Fax #: Email address:

Preferred Communication: (circle one) Home Cell Work Mail Other

Employer: Occupation: Phone #:

ASSOCIATED PARTY/EMERGENCY CONTACT

Last Name: First Name: Date of Birth

Address: City: State: Zip:

Home Phone #:_____ Alt. Phone #: _____ Relationship to Patient _____

Send Statement To: _____ (if different from patient)

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Member's ID #: Group #	Member's ID #: Group #
Name of Policy Holder:	Name of Policy Holder:
Relationship to Patient:	Relationship to Patient:

If Policy holder is other than patient, please complete following information:

Policy Holders Name: Social Security # Date of Birth

Address: City: State: Zip:

Phone Number: Alt. Phone Number: Employer: