PATIENT REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name) Today's Date: _____

Last Name: _____ First Name: _____ M.I.:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____
Preferred contact ☐ Preferred contact ☐

Date of Birth: _____ Age: _____ Gender (circle one): Female Male

Social Security #: _____ Driver's License #: _____

Race: _____ Ethnicity: _____ Preferred Language:_____

Marital Status (circle one): Single Divorced Widowed Married

Spouse: _____ Date of Birth: _____ Social Security #: _____

E-mail Address: _____

Employer Name:_____ Work Phone: (_____) _____

Pharmacy Name and #: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____ Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

GUARANTOR INFORMATION: (List person insured name responsible for bill- use full legal name, no nicknames)

Relationship of Guarantor to Patient: _____Self _____Spouse _____Parent _____Other_____

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Social Security #: _____ Date of Birth: _____ Age: _____ *Sex: _____

INSURANCE INFORMATION (Please allow Receptionist to photocopy your insurance ID cards)

Primary Insurance: Plan Name: _____

Secondary Insurance: Plan Name: _____

How did you hear about US?

- ☐ Physician Dr. _____
- ☐ Mailer/Postcard
- ☐ Friend/Relative: _____
- ☐ Internet (which site): _____
- ☐ Magazine/Newspaper (which one): _____
- ☐ Social Media (circle one): FACEBOOK TWITTER
- ☐ Other:_____