Patient Registration Form

_____ _____
First Middle Last Social Security Number

Date of Birth: _____ Male □ Female □ Marital Status: _____

Address:_____
Street

_____
City State Zip

Home Phone: ( ) _____ Mobile Phone: ( )_____

Preferred Contact Method: Home / Mobile

Email Address: _____

Primary Care Physician: _____ Referring Provider: _____

Pharmacy: _____ Pharmacy Location: _____

Preferred Language: _____

ETHNICITY: Hispanic/Latino Non-Hispanic/Latino Prefer Not to Answer

RACE: American Indian Asian Black/African American White Native Hawaiian/Pacific Islander Other

I DO / DO NOT consent to the office leaving a detailed message containing medical information at any of the phone numbers listed above. (*CIRCLE ONE*)

I DO / DO NOT consent to the office discussing my medical information with: (*CIRCLE ONE*)

Person: _____Relationship to patient: _____
Person: _____Relationship to patient: _____

Emergency Contact Information:

In case of Emergency, whom should we notify? _____
Relationship to Patient: _____ Phone#:( )_____

Insurance Information: Do you have health insurance? **Yes □ No □**

Primary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor Date of Birth: _____

Secondary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor Date of Birth: _____

Patient Signature: _____ Date: _____