Patient Registration Form PLEASE PRINT

PATIENT INFORMATION

Last Name: _____ First Name: _____ M. Initial: _____

DOB: _____ Sex: ☐ Female ☐ Male Social Security Number: _____-_____-_____

Marital Status: _____ email: _____

Home Phone: _____ Cell Phone: _____

PHARMACY NAME & PHONE NUMBER: _____

PARENT OR GUARDIAN INFORMATION *(Only fill out if the patient is under the age of 18)*

Last Name: _____ First Name: _____ M. Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Social Security Number: _____-_____-_____

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

EMPLOYER: _____

PRIMARY & SECONDARY INSURANCE INFORMATION *(ALL insurance)*

Insurance Plan Name: _____

POLICY HOLDER NAME *(if other than patient)*: _____

DOB: _____ Sex: ☐ Female ☐ Male Relationship to Patient: _____

HOW MAY WE CONTACT YOU REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)?

☐ No ☐ Yes: I may be contacted by e-mail at: _____

☐ No ☐ Yes: I may be contacted by phone at: _____

☐ No ☐ Yes: May we leave a message with your PHI at the number you have provided? ***(MUST BE ANSWERED)***

Would you like to receive text messages regarding your appointment, lab results, etc.?

☐ No ☐ Yes: What number? _____

DO YOU WANT ANYONE TO HAVE ACCESS TO YOUR PHI? IF SO, WHO? NAME: _____

Signature: _____ Date: _____

Relationship to Patient: _____

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