PATIENT REGISTRATION FORM

Doctor_____
P #_____

PATIENT INFORMATION

Patient Name: _____
Last First Middle Initial

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex ☐ M ☐ F Social Security #: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced - Spouses Name: _____

Race: ☐ White ☐ African American ☐ American Indian ☐ Asian ☐ Hawaiian/Pacific Is. ☐ Declined

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Employer:_____
Name and Address of Your Employer

Pharmacy: _____ Pharmacy Phone #: _____
Name / City

Whom may we thank for referring you? _____

In case of emergency whom should we notify?_____

Relation to Patient: _____ Daytime Phone # _____ Evening Phone # _____

GUARANTOR INFORMATION

Party Responsible: _____Relation to Patient: _____
Address: _____Phone #: _____
If different from Patient

PRIMARY INSURANCE

Please present your Insurance ID card and Driver's License to receptionist for photocopying

Insurance Company: _____ ID #: _____

Primary Subscriber: _____Date of Birth: _____ Social Security #_____

SECONDARY INSURANCE

Is Patient covered by additional insurance? ☐ Yes ☐ No

Insurance Company: _____ ID #: _____

Primary Subscriber: _____Date of Birth: _____ Social Security #: _____

ADDITIONAL INFORMATION

Was this condition related to a work injury? ☐ Yes ☐ No

Was the injury reported to your Employer? ☐ Yes ☐ No

Was this condition related to a motor vehicle accident? ☐ Yes ☐ No

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED

I hereby authorize the release of any medical information necessary in the processing of my insurance claims. I certify that the above information is complete and correct to the best of my knowledge.

Signature: _____ Date: _____