



Patient Registration
PERSONAL INFORMATION

Patient's Name: _____

- 1. _____ DOB _____ Sex: Male Female (Circle One)
- 2. _____ DOB _____ Sex: Male Female (Circle One)
- 3. _____ DOB _____ Sex: Male Female (Circle One)
- 4. _____ DOB _____ Sex: Male Female (Circle One)

Language spoken at home: _____ Pharmacy name & phone: _____

Race: American Indian/Alaska Native Asian Black/African American
 Native Hawaiian /Other Pacific Islander White Choose not to answer

Ethnicity: Hispanic/Latino Not Hispanic/Latino Choose not to answer

Parent/Guardian: _____ DOB: _____ Relationship to patient(s): _____

Home Address: (Street) _____ (City/State) _____ (Zip) _____

Preferred phone: _____ Cell or Home **Alternate Phone:** _____ Cell or Home

Email Address: _____ Employer: _____

Parent/Guardian: _____ DOB: _____ Relationship to patient(s): _____

Home Address: (Street) _____ (City/State) _____ (Zip) _____

Preferred phone: _____ Cell or Home **Alternate Phone:** _____ Cell or Home

Email Address: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Who referred you to us? _____

INSURANCE INFORMATION

Primary Insurance Co. Information: (name, address and phone # of person responsible for payment)

Insurance Company Name: _____ Phone: _____

Policy/ID Number: _____ Group #: _____ Effective Date: _____

Subscriber's Name: _____ Relationship to Patient _____

Subscriber's DOB: _____

Ins. Address: _____

Secondary Insurance Co. Information: (name, address and phone # of person responsible for payment)

Insurance Company Name: _____ Phone: _____

Policy/ID Number: _____ Group #: _____ Effective Date: _____

Subscriber's Name: _____ Relationship to Patient _____

Subscriber's DOB: _____

Ins. Address: _____

Signature: _____ **Date:** _____