

Patient Registration Form



Patient Information	Patient Information:						
	Last Name:		First Name:		M.I.:	Previous Name (if applicable):	
	Mailing Address:			Apt#:			
	City/State/Zip:						
	Work Phone:		Landline Phone:		Cell Phone:		
	Date of Birth:		Birth Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Preferred Gender _____ Preferred Pronoun (he/she) _____		
	Religion:			Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widow(er) <input type="checkbox"/> Other _____			
	Social Security:			Pharmacy:			
	Veteran Status:						
	Race (please select): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline			Ethnicity (please select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Decline <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unable to obtain			
	Preferred Language (please select one): <input type="checkbox"/> English <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish <input type="checkbox"/> Other						
	Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) <input type="checkbox"/> Voice <input type="checkbox"/> Text				If Voice, Please Select Preferred Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		
	Email Address:						
	Employer Name:			Employer Phone:			
	Emergency Contact Name:				Relationship to Patient:		
Emergency Contact Address:				Phone # <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work			
Primary Care Provider:							
Responsible Party	Responsible Party – Please fill out if not the patient listed above. If the patient is a minor (under 18) the parent or guardian with the patient is the responsible party.						
	Last Name:			First Name:			
	Date of Birth:		Work Phone:		Home Phone:		Cell Phone:
	Address of Responsible party:						
	City/State/Zip:				Relationship to Patient:		
Insurance Information	Primary Medical Insurance						
	Ins. Co. Name:			Ins. Co. Name:			
	Policy Holder Name:			Policy Holder Name:			
	Policy Holder Date of Birth:			Policy Holder Date of Birth:			
	Patient Relationship to Policy Holder:			Patient Relationship to Policy Holder:			
	Member ID:			Member ID:			
	Preferred Pharmacy Name & Location:						
Please review the attached agreement carefully, sign and date. If the patient is a minor (under the age of 18) a parent or guardian is to sign the agreement for the patient.							
Please have insurance card(s) and photo id ready for scanning.							