Patient Registration

First Name: ___________________________________Last Name: ____________________________________ Middle Initial: _______

Patient is: □ Policy Holder □ Responsible Party Preferred Name: ____

Patient Information

Address: ____Address 2: _____________________________________

City, State, Zip: ____

Home Phone: ________________________Work Phone: _______________________Cell Phone: __________________________

Birth Date: ________/________/_________Social Security Number: ________________________________Sex: □ Male □ Female

Email: ____□ I would like to receive correspondences via email and text.

Emergency Contact: ___________________________________ Emergency Contact # ___________________________________

Referred by: _______________________________________Preferred Pharmacy: ______________________________________

Responsible Party *(if someone other than patient)*

First Name: _________________________________ Last Name: ___________________________________ Middle Initial: _____

Address: ____Address 2: _________________________________

City, State, Zip: ____

Home Phone: ________________________Work Phone: _______________________Cell Phone: __________________________

Birth Date: __________/_________/___________Social Security Number: ____

Primary Insurance

Name of Policy Holder: ____Relationship to Patient: □ Self □ Spouse □ Child □ Other

Insurance Company: _______________________________________Insurance Company Phone # _________________________

Mailing address: ____

Policy ID #: ____Group # ____

Employer: ____

Secondary Insurance *(if applicable)*

Name of Policy Holder: ____Relationship to Patient: □ Self □ Spouse □ Child □ Other

Insurance Company: _______________________________________Insurance Company Phone # _________________________

Mailing address: ____

Policy ID #: ____Group # ____

Employer: ____