Patient Registration

First Name: _____Last Name: _____ Middle Initial: _____

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

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: _____

Patient Information

Address: _____Address 2: _____

City, State, Zip: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Birth Date: _____/_____/_____Social Security Number: _____

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

Emergency Contact: _____ Emergency Contact # _____

Referred by: _____Preferred Pharmacy: _____

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: _____