Patient Registration Form

PATIENT INFORMATION:

NAME: (last) ______________________________ (first) ____________________________ (middle initial) __________

BIRTH DATE: _____/ _____/ _____ GENDER: □ Female □ Male SOCIAL SECURITY NUMBER: _____________________

ADDRESS: ____________________________________ CITY: _________________ STATE: ___________ ZIP: __________

MARITAL STATUS: _______________________ EMAIL: ____

HOME PHONE: ____________________ WORK PHONE: ___________________ MOBILE PHONE: ___________________

Race: □ Asian □ African American □ Caucasian □ Native American □ Hispanic □ American Indian □ Native Hawaiian □ Pacific Islander □ More than one race □ Other □ Declined **Ethnicity**: □ Latino/Hispanic □ Other □ Declined

Do you have a living will? □ Yes □ No **Do you have a power of attorney?** □ Yes □ No

EMPLOYER: ____ EMPLOYER PHONE: _________________________

EMERGENCY CONTACT: _______________________________ RELATIONSHIP: ___________ PHONE: _______________

REFERRING PHYSICIAN/PRIMARY CARE PHYSICIAN/PHARMACY INFORMATION:

Referring Physician: ____ Phone: ( ) _________-___________

Primary Care Physician: ____ Phone: ( ) _________-___________

Pharmacy Name: ______________________________ Location: _______________________ Phone: _____________________

INSURANCE INFORMATION:

PRIMARY INSURANCE: ______________________ GROUP #: _________________ POLICY/ID #: _______________________

INSURED NAME: ( ) Same as Patient or _____________________ PHONE: _____________ DATE OF BIRTH: ______________

INSURED SS#: (if different than patient) ___________________________ RELATIONSHIP TO PATIENT: ______________

INSURED ADDRESS: ( ) Same as Patient or ____ INSURED: □ Female □ Male

EMPLOYER INSURANCE PLAN: □ Y □ N NAME OF EMPLOYER: ____

SECONDARY INSURANCE: _____________________ GROUP #: _________________ POLICY/ID #: _____________________

INSURED NAME: ( ) Same as Patient or _____________________ PHONE: _____________ DATE OF BIRTH: _______________

INSURED SS#: (if different than patient) _____________________________RELATIONSHIP TO PATIENT: _________________

INSURED ADDRESS: ( ) Same as Patient or ____ INSURED: □ Female □ Male

EMPLOYER INSURANCE PLAN: □ Y □ N NAME OF EMPLOYER: ____

PATIENT SIGNATURE: ____ DATE: ____________________________