PATIENT REGISTRATION

Patient Name				Date	
Birthdate		Age		SS #	
Sex				Salutation	Mr. Mrs. Ms. Dr. (Circle One)
Address					
Pharmacy/Location:					

COMMUNICATION					
Home Phone#					
Cell Phone #		Work Phone #		Extension	
Preferred Contact #		Cell Phone Carrier			
Email					

INFORMATION			
Primary Physician		HIPAA Signed	
Primary Language		Special Needs	
Race		Ethnicity	
Marital Status		Health History Reviewed	
Your Occupation		Employer	

ACCOUNT RESPONSIBLE					
Responsible				Salutation	
Relationship				SS #	
Address					
Home Phone #		Work Phone #		Extension	
Email					

PRIMARY INSURANCE			
Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	

SECONDARY INSURANCE			
Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	

EMERGENCY CONTACT						
First	Last	Relationship	Home#	Cell#	Work#	Ext