Patient Registration Form

Patient Information

SS#:

Name:

Address:

City	State	Zip

Home Phone:

Cell Phone:

Work Phone:

Employer:

Occupation:

Primary Insurance Information

Insurance Company Name:

Address:

Policy Number:	Group Number:
Policy Holder Name:	Date of Birth:

Policy Holder Social Security #:

Relationship to Policy Holder:

Employer of Policy Holder:

Address:

City	State	Zip Code

Telephone #:

Referring Physician (if not primary care physician)

Name:

Telephone #:

Primary Care Physician

Name:

Telephone #:

Pharmacy:

Telephone #:

Mail Order Pharmacy:

Patient Information

☐ Male ☐ Female	Date of Birth:	Age:

Marital Status:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: (for medical purposes – optional)
☐ African American ☐ White ☐ Hispanic ☐ Asian ☐ Other

Email address:

Emergency Contact

Name:

Relationship:

Telephone #:

☐Person responsible for bills (if other than patient)

Name:

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Child

Secondary Insurance Information

Insurance Company Name:

Address:

Policy Number:	Group Number:
Policy Holder Name:	Date of Birth:

Policy Holder Social Security #:

Relationship of Patient to Policy Holder:

Employer of Policy Holder:

Address:

City	State	Zip Code

Telephone #:

Living Will

Do you have a living will? ☐ Yes ☐ No

Additional Information

May we call your work? ☐ Yes ☐ No

May we call your home? ☐ Yes ☐ No

May we leave a message on your answering machine regarding the following:

- **Reminding you of appointments?**
- **Asking you to call the office back?**
- **Inform you that a prescription has been called in to your pharmacy?**

☐ Yes ☐ No

May we leave a message with a member of your household for the reasons above? ***(****We are not allowed to give others your medical information****).*** ☐ Yes ☐ No

Patient / Authorized Party Signature Date