Patient Registration Form

Patient Name: _____ Social Security Number:_____-_____-_____

Date of Birth:_____/_____/_____ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Address: _____

Race:_____ Religion:_____ Primary Language:_____

Home Phone: (_____) _____-_____ Work: (_____) _____-_____ Cell phone: (_____) _____-_____

Email: _____

How would you like our office to contact you? (email, home or cell phone) _____

Preferred Pharmacy:

Pharmacy Name:_____ Address:_____

Pharmacy Phone:(_____) _____ Pharmacy Fax:(_____) _____

Emergency Contact:

Name:_____ Address: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Relationship: _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name:_____ Social Security Number: _____-_____-_____

Relationship to patient: (please check): ( ) self, ( ) spouse, or ( ) parent

Date of Birth: _____-_____-_____

Phone: _____

Address: _____

I understand that I am financially responsible for any co-payments, co-insurance, deductibles, and non-covered services outlined in my health plan. This agreement applies to all visits that take place one year from the date this is signed and any bills resulting from those visits.

Parent/Guarantor Signature: _____ Date: _____/_____/_____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.