# PATIENT REGISTRATION PLEASE PRINT TODAY’S DATE:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| First Name | Middle Initial | Last Name | Gender |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Address | Apt | City | State | Zip |

# 

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Home Phone | Cell Phone | E-Mail |

|  |  |
| --- | --- |
| Birth Date: | **Relationship to Insured:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Social Security #: |  | **Preferred Language:** |  |

**Race:** □ American Indian or Alaska Native □ Native Hawaiian or Pacific Islander **Ethnicity:**

□ White □ Black or African American □ Asian □ Hispanic or Latino □ Not Hispanic or Latino

□ Decline to Answer □ Decline to Answer

**Nature of Problem:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date Illness First Appeared)

**If You Are a Minor, Fill in Your Parent’s Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Referring Physician: |  |

(Name, Address & Phone # of Referring Physician)

Primary Care Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACY INFORMATION**

|  |  |
| --- | --- |
| **Name of Pharmacy:** | **Phone # of Pharmacy:** |
| **Address of Pharmacy**: | **Prescription Benefit ID#** : |

## INSURANCE INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Insurance** | | **Additional Insurance** | |
| Insurance Plan/Company |  | Insurance Plan/Company |  |
| Insurance Address: |  | Insurance Address: |  |
| Subscriber’s ID #: |  | Subscriber’s ID #: |  |
| Patient Relationship to insured |  | Patient Relationship to insured |  |
| Name of Subscriber: |  | Name of Subscriber: |  |
| Address of Subscriber  Phone #: |  | Address of Subscriber  :  Phone #: |  |
| Social Security # of Subscriber: |  | Social Security # of Subscriber: |  |
| Birth Date of Subscriber |  | Birth Date of Subscriber |  |

A copy of this signature for release of information to your insurance company, for submission of claims, or a referring physician is as valid as the original.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_