# Patient Registration Form

Patient Legal Name: _____ Preferred first name:_____

DOB: _____ ☐ Male ☐Female SSN:_____

Primary Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Cell#: _____

Secondary Address: _____

City: _____ State: _____ Zip: _____

Alternate Phone#: _____ Type ☐Home ☐ Cell ☐Work

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian or Other Pacific Islander ☐ White ☐Other ☐Decline

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline

Primary Language:_____

Preferred method(s) of contact: ☐Mail ☐Email ☐Home Phone ☐Cell Phone ☐Text ☐Online Patient Portal

Personal Email:_____

Pharmacy Name/Location:_____ Pharmacy Phone: _____

Primary Care Physician:_____

Whom may we thank for referring/recommending you to our practice:_____

Employment Status: ☐Employed ☐Self-Employed ☐Retired ☐Disabled ☐Unemployed ☐Student

Occupation:_____Employer_____

Employer Address_____ Work Phone: _____

## *EMERGENCY CONTACTS*

#1. Name: _____ Relationship: _____ Phone#: _____

#2. Name: _____ Relationship: _____ Phone#: _____

## *INSURANCE INFORMATION*

Primary Insurance Carrier: _____ Eligibility Phone#: _____

Policy holder ID: _____Group ID:_____

Policyholder's Name: _____ Date of Birth_____ Sex: ☐ Male ☐Female

Policyholder's SS#: _____ Relationship to patient: _____

Secondary Insurance Carrier: _____ Eligibility Phone#: _____

Policy holder ID: _____Group ID:_____

Policyholder's Name: _____ Date of Birth_____ Sex: ☐ Male ☐Female

Policyholder's SS#: _____ Relationship to patient: _____