PATIENT INFORMATION:

Last Name: ___________________________ First Name: ________________________ MI: _____ DOB: _____/______/_______

SSN #: ______-______-_______ Gender: ___ Male ___ Female Marital Status: ___________ Nickname: __________________

Email: ____________________________ Race: _____________ Language: _______________ Ethnicity: ____________________

Address: ____

Home Phone: __________________________ Cell Phone: _______________________ Work Phone: ______________________

Contact Preference: __________________ Employer: ___________________________ Occupation: ______________________

How did you hear about us? (*check all that apply*) ____ Facebook/Instagram ____ Online search (Google, Bing, etc.) ____ Yelp

____ Friends/Family ____ Healthgrades/Vitals ____ Practice/Hospital website ____ Other: _____________________

PHARMACY:

Pharmacy Name: ___________________________________ Address: ____

Phone Number: _____________________________________ Is this a Mail Order Pharmacy? ____ YES ____NO

INSURANCE INFORMATION:

Insurance Co. Name: ______________________________________ Policy Number: _____________________________________

Policy Holder's Name: __________________________ Relation: ______________DOB: _____/_____/______ Sex: M F

Employer: ____ Employer Phone Number:________________________________

◯ *Check here if address is same as patients or add current Address:* ____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: ______________________ Phone Number: ____________________ Relationship: _________ _______

PARENT/GUARDIAN INFORMATION: (***Fill this Section only if this registration is for a child under 18***)

Last Name: ________________________First Name: _____________________________ MI: _____ DOB: _____/______/_____

◯ *Check here if address is same as patients or add current Address*: ____

Home Phone: __________________________ Cell Phone: ___________________________ Contact Preference: _______________

Please hand receptionist all current insurance cards and photo identification once you have completed this form. Co-Payments will be collected at time of visit.

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