PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHIC INFORMATION

Full Name____ Height: ________Weight__________

(Please Circle)

SS#_______-______-________ Date of Birth _____/______/______ Marital Status: S M W Sep D

Street Address: ____City: ___________________________

State____________ Zip Code: _____________ Gender: Male ☐ Female ☐

***please note this information is for reporting purposes only.**

Race (circle one):
- African American
- White
- Asian
- Hispanic
- American Indian
- Native Hawaiian or other Pacific Islander
- Other Race
- Refuse to Report

Ethnicity:
- Hispanic or Latino
- Not Hispanic or Latino
- Refused to Report

Language:
- English
- Spanish
- Other _______________

Please check box off for preferred phone:

☐ Home Phone: _________________ ☐ Cell Phone: ________________ ☐ Work phone:_______________

Preferred time of day for Reminder Calls: Morning _____ Afternoon ______ Evening ______

Email Address: ____@___________________________

Pharmacy: _______________________Pharmacy Address:_______________________________________

Emergency Contact Name:____

Emergency Phone: _____________________Relationship: _________________________

PATIENT EMPLOYER INFORMATION

Employer Name____ Tel #__________________________

Employer Street Address___________________________City/State______________Zip Code__________

Patients Occupation:__________________________ Employment Status: FT/PT/Retired/Unemployed

INSURANCE

Primary Insurance Company Name____

ID#__________________________________ Group #____________________Tel #__________________

Secondary Insurance Company Name____

ID#__________________________________ Group #____________________Tel #__________________

INSURED PERSON (IF NOT PATIENT)

Name____ Tel #____________________________

Street Address___________________________________ City/State______________ Zip Code__________

Relationship to Patient_____________________________ DOB of Insured_________________________