Patient Registration Form

Patient Name _____ Date of Birth _____

***Please Circle*: Gender** Male Female **Marital Status**: Single Married Divorced Widowed

Address _____

City_____State_____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

Preferred Language_____Ethnicity_____Race_____

Email Address _____

Pharmacy Name_____ Pharmacy Phone_____

Please indicate your preferred method for appointment reminders from this office:

Text Message, Telephone Call (please provide number_____) Email_____

Other _____

If the practice does not have the capability for text or email reminders, the phone number will be utilized for reminders.

If Guarantor is other than the patient please complete the information below:

Name_____Relationship to Patient_____

Address _____

City_____State_____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

Email Address:_____ Guarantor Date of Birth _____

Employer_____ Employer Phone_____

Referring Physician Information

Name_____Specialty_____Phone_____Fax_____

Does your insurance require a referral? __YES __NO; **if yes**, please provide the referral to the receptionist

Primary Care Physician Information, if other than above

Name_____Specialty_____Phone_____Fax_____

Emergency Contacts Information and Relationship to Patient

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Primary Insurance _____Phone Number_____

Name of Policy Holder_____Policy Holder's Date of Birth_____

Policy #_____Group/Plan#_____

Effective Date of Policy _____

*Secondary Insurance _____Phone Number_____

Name of Policy Holder_____Policy Holder's Date of Birth_____

Policy #_____Group/Plan#_____

Effective Date of Policy_____

Patient/Guarantor Signature_____Date_____

Witness Signature_____Date_____