REGISTRATION FORM

Section I: Patient Information

Date_____

Name: _____

Address: _____**City:**_____**State:**_____**Zip**_____

Phone: (_____) _____ **Cell:** (_____) _____ **Work:** (____)_____

Date of Birth: _____ **Social Security Number:** _____

Email Address: _____

Employer: _____ **Work Address:** _____ ☐ **Retired**

Check Appropriate Box: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Race: ☐ **African American** ☐ **Asian** ☐ **White** ☐ **American Indian** ☐ **Other**

Ethnicity: ☐ **Hispanic / Latino** ☐ **Non Hispanic or Latino**

Religion: ☐ **Catholic** ☐ **Protestant** ☐ **Islam** ☐ **Jewish** ☐ **Other**

Pharmacy: _____ **City:** _____ **State:** _____ **Phone:** _____

Spouse Name: _____ **Employer:** _____ **Work Phone:** _____

Emergency Contact: _____ **Phone:** _____

Section II Responsible Party

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip**: _____ **Phone:** (____) _____

Employer: _____ **Work Phone** (____) _____

Person who holds Insurance: _____ **SSN #**_____**DOB:**_____

Section III Insurance Information

Primary Insurance: Name of Insured_____ **DOB** _____

Insurance Company_____ **Group #**_____ **ID#**_____

Secondary Insurance: Name of Insured_____ **DOB**_____

Insurance Company_____ **Group #**_____ _ **ID#**_____