PATIENT REGISTRATION **PLEASE PRINT** **TODAY'S DATE:**

First Name | Middle Initial | Last Name | Gender

Address | Apt | City | State | Zip

Home Phone | Cell Phone | E-Mail

Birth Date: **Relationship to Insured:**

Social Security #: **Preferred Language:**

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander

☐ White ☐ Black or African American ☐ Asian

☐ Decline to Answer

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Decline to Answer

Nature of Problem: _____ **Date:** _____ Occupation: _____
(Date Illness First Appeared)

If You Are a Minor, Fill in Your Parent's Name : _____

Referring Physician: _____
(Name, Address & Phone # of Referring Physician)

Primary Care Doctor: _____

PHARMACY INFORMATION

Name of Pharmacy: **Phone # of Pharmacy:**

Address of Pharmacy: **Prescription Benefit ID#** :

INSURANCE INFORMATION

Primary Insurance	**Additional Insurance**
Insurance Plan/Company	Insurance Plan/Company
Insurance Address:	Insurance Address:
Subscriber's ID #:	Subscriber's ID #:
Patient Relationship to insured	Patient Relationship to insured
Name of Subscriber:	Name of Subscriber:
Address of Subscriber	Address of Subscriber
Phone #:	Phone #:
Social Security # of Subscriber:	Social Security # of Subscriber:
Birth Date of Subscriber	Birth Date of Subscriber

A copy of this signature for release of information to your insurance company, for submission of claims, or a referring physician is as valid as the original.

Signed: _____ Date: _____