PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHIC INFORMATION

Full Name_____ Height: _____Weight_____

SS#_____-_____-_____ Date of Birth _____/_____/_____ **(Please Circle)** 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_____