<u>Patient Registration</u> (Please Print)

Last Name: ________________________________ First Name: _______________________________ M ______

Date of Birth: ____________ SS#: ________________________ Sex: ___________ Marital Status:___________

Street Address: ____ Apt:_____________

City: ____ State: ______________ Zip: ________________

Home Phone: ___________________________ Work: ______________________ Cell:____________________

Race: [ ] Caucasian
[ ] Black of African American
[ ] American Indian or Alaska Native
[ ] Hawaiian or Other Pacific Islander
[ ] Other race

Ethnicity: [ ] Hispanic or Latino
[ ] Not Hispanic of Latino
[ ] Unknown

Preferred Language: _____________________ Email: ______________________ Employer: __________________

Pharmacy: _______________________ Location: _________________________ Phone: _____________________

How did you hear about us: ____

Emergency Contact: ____

Relationship to Patient: _________________________________ Phone: _________________________________

Primary Insurance Policy Holder: ________________________________ Date of Birth: ____________________

Relationship to Patient: ___________________ Address: ____

Secondary Insurance Policy Holder: ________________________________ Date of Birth: __________________

Relationship to Patient: ___________________ Address: ____

Disclaimer: