Registration Form

Patient Information

☐ Patient holds Insurance ☐Someone else holds insurance
☐Guarantor holds insurance ☐No Insurance

☐New Patient ☐Established Patient

Full name:

Date of Birth: Gender: ☐Male ☐Female

Social Security Number:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Race: ☐American Indian ☐ African American ☐White
☐Asian ☐Hawaiian Native ☐Other Race ☐Decline

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/ non-Latino

Mailing Address:

City: State: Zip:

Preferred Phone #: ☐Home ☐Cell ☐Work

Secondary Phone #: ☐Home ☐Cell ☐Work

E-mail Address: ☐e-Bill me!

Emergency Contact: Phone #:

Who is your Primary Care provider?

How did you hear about us?

Signature:

Do you authorize us to check your medication history? ☐Yes ☐No

Guarantor or Insurance holder Information

☐Guarantor ☐Insurance holder

Full name:

Date of Birth

Relationship to Patient:

Mailing address:

City: State: Zip:

Preferred Phone #: ☐Home ☐Cell ☐Work

E-mail Address: ☐e-Bill me!

Medical Information

Visit Reason: Date: ___ /___ /___

Allergies:

Medical problems:

Surgical history:

Current Medication:

Preferred Pharmacy:

Smoker? ☐Yes ☐No
Frequency:

If female, is there a chance you are pregnant? ☐Yes ☐No

By signing here, you certify that this information in correct and valid