Welcome!

REGISTRATION FORM

Section I: **Patient Information** **Date:**

Name:____ I Prefer to be called: __________________________
Address:____City:_____________State:_______Zip________________
Phone _________________________ Work Phone _____ _______________ Cell Phone_________________________
The best time to contact me is:________________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____________ Social Security Number:____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Spouse or Parent's Name:___________________________ Employer_________________ Work ____________
Whom may we thank for referring you?
____
Person to contact in case of emergency____
Phone____
Email Address___________________________________ 2nd Email address________________________________
Pharmacy__________________________Address/Phone____

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:____ Relationship to Patient: ____________________
Address:____
City:______________________________ State:_________ Zip:___________ Phone: (___)___________________
Employer_______________________ Work Phone (___)_______________ SSN#__________________________

Section III **Insurance Information**

Name of Insured___________________________DOB___________Relationship to Patient _________________
SSN#:______________________ Name of Employer:__________________ Work Phone: (___)_____________
Address of Employer:_______________________________City_______________State:_______Zip _________
Insurance Company__________________________ Group #____
ID#____________________________________ Ins Co____
Address:____
Please bring your Insurance card to the Front Desk for photocopying!! Thank you!!