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Patient Registration Form

Please Print

Patient Name: _____ (Last), _____ (First), _____ (M.I.) Sex: ☐ Male ☐ Female

Date of Birth: _____ (Month) /_____ (Day) /_____ (Year) Age: _____ SSN: _____-_____-_____ ☐ Single ☐ Married ☐ Wid ☐ Sep ☐ Div

Responsible Party (if minor): _____ Email: _____

Home: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

Best number to be reached at: Home Work Cell (Circle one) Second best number to be reached at: Home Work Cell (Circle one)

Home Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____-_____

Employer: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Purpose of Visit: _____ Pharmacy Phone Number_____

Do you have medical insurance? ☐ Yes ☐ No **If yes**, please fill out boxed section below

Subscriber (If different from patient): _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ (Month)/_____ (Day)/_____ (Year) Age: _____ SSN: _____-_____-_____ ☐ Single ☐ Married ☐ Wid ☐ Sep ☐ Div

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian

Employer: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Name of Insurance: _____

Address: _____ Phone: (_____) _____-_____

ID No. _____ Group No. _____ Effective Date _____ (Month)/_____ (Day)/_____ (Year)

Party Responsible for this Account: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian Responsible Party's SSN: _____-_____-_____

Home: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

Primary Care Physician: _____ Phone: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for your referral: _____

Assignment of Benefits

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. If I do not provide your office with a referral when required, I will be responsible for the payment. **I understand and agree that I am financially responsible for charges not paid by my insurance company.**

_____

Signature of Patient, Insured, or Beneficiary *or* Parent/Guardian (if patient is minor)

_____/_____/_____ (Month / Day / Year)

Today's Date