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| **PATIENT REGISTRATION FORM** |

**Date: \_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_**

**Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_\_\_\_\_\_\_**

**SSN: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_**

**Marital Status: □ Single □ Married □ Divorced □ Widowed □ Domestic Partner □ Other**

**Race: □ White □ Black/African America □ Native Hawaiian/Pacific □ Asian □ Hispanic**

**□ Other □ Declined**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Work Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Cell Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Method of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_**

**Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_**

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| **Primary Insurance Company:** | **Insurance ID:** |
| **Subscriber’s Name (as it appears on the card):** | **Subscriber’s Date of Birth:** |
| **Patient Relationship to Subscriber: □ Self □ Spouse □ Dependent** | |
| **Secondary Insurance Company:** | **Insurance ID:** |
| **Subscriber’s Name (as it appears on the card):** | **Subscriber’s Date of Birth:** |
| **Patient Relationship to Subscriber: □ Self □ Spouse □ Dependent** | |