PLEASE COMPLETE FORMS IN THEIR ENTIRETY, TO EXPEDITE THE REGISTRATION PROCESS

BLACK INK ONLY

PATIENT INFORMATION

LAST NAME | FIRST NAME | MI | TITLE | NICKNAME | GENDER | AGE

HOME PHONE | CELL PHONE | SOCIAL SECURITY # | DOB (M/D/Y)

HOME ADDRESS | CITY, STATE ZIP

EMAIL ADDRESS (used for the patient portal and appointment reminders)

OCCUPATION / STUDENT | EMPLOYER | MARITAL STATUS

GUARANTOR / RESPONSIBLE PARTY for minor children only: Responsible Party is the parent who completes and signs this form.

FIRST AND LAST NAME OF INSURED | EMPLOYER | RELATIONSHIP TO PATIENT

HOME PHONE | CELL PHONE | SOCIAL SECURITY # | DOB (M/D/Y)

HOME ADDRESS | CITY, STATE ZIP

INSURANCE INFORMATION – Please provide insurance cards and ID to front desk staff

Name of Primary Insurance Company | Name of Secondary Insurance Company | Name of Tertiary Insurance Company

PHARMACY INFORMATION

PHARMACY NAME | PHARMACY LOCATION (if location is unknown, please provider CITY and nearest cross streets)

PHARMACY PHONE NUMBER _____

Referring Physician (IF APPLICABLE)

_____PHONE:_____