



Patient Registration Form

Patient Information:

Patient Name: (Last) _____ (First) _____ (MI) _____

Date of Birth (DOB): _____ Sex: Female Male Transgender

Social Security Number (SS#): _____ - _____ - _____

Address: _____

City, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone _____

Marital Status: Single Married Divorced Widowed Legally Separated Unknown

Employer Name: _____ Employer Department: _____

Employee % (If applicable) _____ Medicare Enrolled (check): ___ Part A ___ Part B ___ Part D

How did you hear about us:

_____ Website _____ Co-worker _____ New Hire Orientation _____ Newsletter

Other, please describe: _____

Responsible Party/Policy Holder (If Other Than Patient):

Policy Holder's Name: (Last) _____ (First) _____

Policy Holder's Date of Birth (DOB): _____ Insurance Company _____

Policy # _____ Group # _____

Policy Holder's Social Security Number (SS#): _____ - _____ - _____

Additional Information:

Email Address: _____ * email address is required in order to access the Patient Portal

Pharmacy Name/Location: _____

Race: American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Black or African American White Declined

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Declined

Language: English Spanish Indian Japanese Chinese Korean French German Russian Other _____

Emergency Contact Information:

Emergency Contact: (Last) _____ (First) _____

Phone Number: (1) _____ (2) _____

Emergency Contact Relationship to Patient: _____

Current Physician's Names:

Primary Care Provider (PCP): _____

Any Other Physician: _____

I acknowledge that the information provided on this form is accurate and up-to-date to the best of my knowledge. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that a request for medical information from persons not listed above will require a specific authorization prior to disclosure of any medical information.

Patient Signature / Guardian Signature

Date