



### PATIENT REGISTRATION

#### DEMOGRAPHIC INFORMATION

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ (mm/dd/yyyy) SEX: \_\_\_\_\_ RACE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_

ADDRESS 1: \_\_\_\_\_ ADDRESS 2: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

LANGUAGE: \_\_\_\_\_ LANGUAGE COUNTRY: \_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED  PARTNER  DIVORCED  WIDOWED

PREGNANT (check if applicable)  NURSING (check if applicable)

Whom may we thank for referring you to our practice? \_\_\_\_\_

#### CONTACT INFORMATION

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

#### EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: \_\_\_\_\_ CONTACT LAST NAME: \_\_\_\_\_

CONTACT HOME PHONE: \_\_\_\_\_ CONTACT CELL PHONE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ CONTACT ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

#### FAMILY MEMBERS IN THE PRACTICE

\_\_\_\_\_ (name) \_\_\_\_\_ (relationship to patient)

\_\_\_\_\_ (name) \_\_\_\_\_ (relationship to patient)

\_\_\_\_\_ (name) \_\_\_\_\_ (relationship to patient)

\_\_\_\_\_ (name) \_\_\_\_\_ (relationship to patient)

#### PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: \_\_\_\_\_ PRACTICE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ PHARMACY PHONE: \_\_\_\_\_

PHARMACY LOCATION: \_\_\_\_\_

**By signing below, I attest that the information provided above is true and accurate**

**Signature of Insured / Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_