PATIENT REGISTRATION

Date ______________

Date of Birth ____

Patient Name ____
Last Name First Name Middle Inttial

Address ____
Street City State Zip

E-mail ______________________ Sex ☐ M ☐ F Age _____ Minor ☐

Primary Care Physician:

____

Pharmacy ______________________________

Pharmacy Address ______________________________

Home Phone ( ) ______________ Cell Phone ( ) ______________ Work Phone ( ) ______________ Ext. ____

Best Time and Place to Reach You ____

Social Security # ______________________________ Drivers License # ______________________

Religion:

☐ Buddhist ☐ Catholic ☐ Hindu ☐ Islam ☐ Jehovah's Witness ☐ Jewish ☐ Mormon ☐ Protestant
☐ Unknown ☐ N/A ☐ Other ______________________________

Marital Status:

☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Select one of the following Race/Ethnic Groups:

☐ Hispanic ☐ Black ☐ White ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander

Occupation ____

Patient Employer/School ____

Employer/School Address ____

Employer/School Phone ( ) ______________________

Spouse's Information:

Spouse's Name ______________________________________ Date of Birth ____________

Employer ______________________________________ Social Security # ______________________

Minor Information:

Guardian/Custodial Parent Name ____

Guardian/Custodial Parent Address ____
Street City State Zip

Home Phone ( ) ______________ Cell Phone ( ) ______________ Work Phone ( ) ______________ Ext. ____

Employer ______________________________________ Social Security # ______________________

Whom may we thank for referring you? ____

IN CASE OF EMERGENCY, CONTACT

Name ______________________________

Home Phone ( ) ______________________________

Cell Phone ( ) ______________________________

Work Phone ( ) ______________________________ Ext. ____

Preferred Communication Method:

☐ email ☐ voice ☐ text