PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last, First, M.I.)

Former Names (Maiden, etc.) | Preferred Name (Nickname, etc.)

Birthdate / / | Age | SSN

Marital Status (Circle one): Single Married Divorced Widowed Separated | Driver's License # | Primary Language

Race (Circle one): American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander Caucasian Other Declined

Ethnicity (Circle one): Hispanic/Latino Non-Hispanic/Latino Declined

Address Apt. # | City | State | Zip

Home ( ) | Work ( ) | Cell ( ) | Primary Number (Circle one) Home Work Cell

Email Personal | **Permission to access past medication history (PBM)** **Yes** **No**

Employed by | Occupation

Primary Care Physician | Referred by | **Preferred Pharmacy & Location**

Spouse's Name (Last, First, M.I.) | Birthdate / /

Employed by | Occupation

Local Emergency Contact Name | **Relationship** | **Phone**

AUTHORIZATION TO SHARE HEALTH CARE INFORMATION

You may share the following health care information with:

Name: ______________________ Relationship: ______________________

Please check all that apply:

☐ All health care information in my medical record ☐ Insurance and billing information

☐ Health care information in my medical record relating to the following treatment: ______________

This authorization will be in effect until otherwise notified by the patient.

- May leave detailed message on voicemail at: Home #:__________ Work #: __________ Cell #: __________

INSURANCE INFORMATION

Primary Insurance Company: ______________________

Name of Insured: ______________________ Date of Birth: ______________

Relationship to Insured: ______________________ Group Number: ______________

Insurance ID Number: ______________________

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to process my claim. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account.

No-Show/Late Cancellation Policy: It is very important that you call within 24 hours in advance to cancel your appointment. On your second no-show/late cancel occurrence, there will be a $50 charge to your account.

I have reviewed and verified that all information above is true and correct and agree to all the terms and conditions stated herein.

X Signature: ______________________ Date: ______________

(PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST)