Patient Registration Form

Patient Name:____

Last Name First Name Middle

Address:____

Street or Box City State Zip

Phone: (Primary) __________________ (Cell) ______________ (Work) __________________

Date of Birth: ____________________ Email:____________________________________

Gender: ☐ Male ☐ Female SS# ________________________________

Marital Status: ☐ Single ☐ Married ☐ Widow/Widower ☐ Divorce

Employment Status: ☐ Full Time ☐ Part Time

Employer:____

Student: ☐ Full Time ☐ Part Time ☐ N/A

School:____

Spouse Name: _________________________DOB: ______________SS#___________________

Race: ☐ American Indian or Alaskan Native ☐ White

☐ African-American ☐ Hispanic

☐ Asian ☐ Native Hawaiian

☐ Other: ____________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Language Spoken: ______________________

Drivers License#: _____________________ State: _______________________

Referred By: ____

Emergency Contact Name: _____________________________Relationship: __________________

Daytime Phone: _______________________________Evening Phone: ______________________

Name of Preferred Local Pharmacy: ________________________Telephone:_________________

Address: ____

Mail Order Pharmacy: ____

How did you hear about us: ☐ Newspaper Ad ☐ TV/Radio Ad ☐ Yellow Pages

☐ Family/Friend Referral ☐ Internet ☐ Other__________________________

Reason for visit:____

Primary Care Physician:_____________________________Telephone:_______________________

Please complete if PATIENT is a student or minor:

Mother's Name: _______________________________ DOB: ______________ SS#___________________

Address: ______________________________________ Phone: __________________

Father's Name: ________________________________ DOB:__________________ SS# _____________

Address: _______________________________________Phone: ___________________