

# REGISTRATION INFORMATION

(please print)

Date: \_\_\_\_\_ PCP: \_\_\_\_\_  
Last Name: \_\_\_\_\_ Referring Provider: \_\_\_\_\_  
First Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Maiden Name: \_\_\_\_\_ Gender (circle): Male Female  
Street Address: \_\_\_\_\_ May we use email to contact you? (circle) Y N  
City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

May we leave messages/results for you on your voice mail/answering machine/email? (circle) Yes No

\* In emergency notify: (*person not living with you*) \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy/Location: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_

\_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Mail Order Pharmacy \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

\_\_\_\_\_ Spouse's Work No.: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Person Responsible for Payment: \_\_\_\_\_

Race (optional): \_\_\_\_\_ Relationship: \_\_\_\_\_

Ethnicity (optional): \_\_\_ Hispanic \_\_\_ Non-Hispanic Email Address: \_\_\_\_\_

## PRIMARY INSURANCE

Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Group No.: \_\_\_\_\_ Subscriber No. or ID No.: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Subscriber Employed By: \_\_\_\_\_ Address: \_\_\_\_\_

## SECONDARY INSURANCE

Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Group No.: \_\_\_\_\_ Subscriber No. or ID No.: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Subscriber Employed By: \_\_\_\_\_ Address: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

(\*\*if patient is a child, please complete both sides of form\*\*)

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**FATHER'S INFORMATION/LEGAL GUARDIAN**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last Name

First Name

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Soc. Sec. No.: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**MOTHER'S INFORMATION/LEGAL GUARDIAN**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last Name

First Name

(Maiden)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Soc. Sec. No.: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature of Person Completing Form: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_