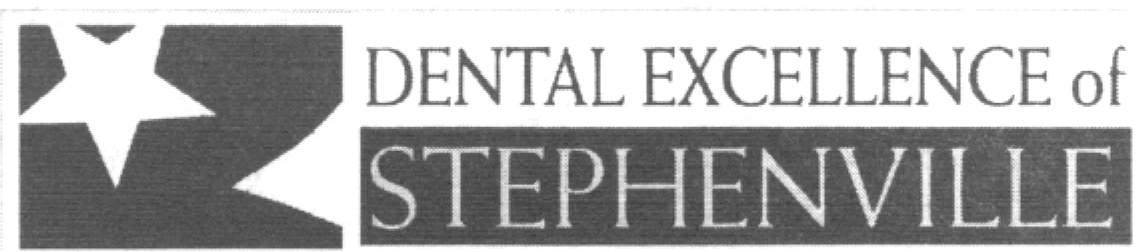

Patient Registration

First Name:______________________ Last Name:______________________

Patient is: ☐ Policy Holder
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name:______________________ Last Name:______________________

Address:______________________ Second Address:______________________

City, State, Zip:______________________ Pager:______________________

Home Phone:__________ Work Phone:__________ Ext.:______ Cellular:__________

Birth Date:__________ Age:______ Soc. Sec.:__________ Drivers Lic.: __________

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder

Patient Information

Address:______________________ Second Address:______________________

City:______________________ State / Zip:______________________ Pager:__________

Home Phone:__________ Work Phone:__________ Ext.:______ Cellular:__________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date:__________ Age:______ Name of Spouse:______________________

Soc. Sec.:______________________ Driver Lic.:______________________

E-mail:______________________ ☐ I would like to receive correspondence via e-mail

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Place of Employment:______________________

Student Status: ☐ Full Time ☐ Part Time

Preferred Pharmacy:______________________ Referred by:______________________

Contact Information

In case of an Emergency, Please Contact: (Please do NOT put name of person in the same household)

Name:______________________ Address:______________________

Home Phone:______________________ Work Phone:______________________

Primary Insurance Information

Name of Insured:______________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.:______________________ Insured Date of Birth:______________________

Employer:______________________ Insurance Company:______________________

Address:______________________ Address:______________________

City,State,Zip:______________________ City,State,Zip:______________________

Phone #:______________________ Phone #:______________________