

**PATIENT REGISTRATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder  Responsible Party Preferred Name: \_\_\_\_\_

**Responsible Party (If it is someone other than patient, Otherwise skip this section)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible party is also Policy Holder for Patient  Primary Ins Policy Holder  Secondary Ins Policy Holder

**Patient Information**

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_ I would like to receive correspondences via e-mail.

Employment Status  Full time  Part Time  Retired

Student Status  Full Time  Part Time

Medicaid ID: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Insured: \_\_\_Self \_\_\_Spouse \_\_\_Child \_\_\_Other

Insured Soc. Sec \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

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

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

Address 2: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Ins. Company: \_\_\_\_\_

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

Address 2: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**Secondary Insurance Information** (if You Have a 2<sup>nd</sup> Insurance)

Name of Insured \_\_\_\_\_ Relationship to Insured: \_\_\_Self \_\_\_Spouse \_\_\_Child \_\_\_Other

Insured Soc. Sec \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

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

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

Address 2: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Ins. Company: \_\_\_\_\_

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

Address 2: \_\_\_\_\_

City, State, Zip \_\_\_\_\_