

**REGISTRATION FORM - Bring to Your Appointment**



**PATIENT INFORMATION**

Full Legal Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ M: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

Marital Status: \_\_\_Single \_\_\_Married \_\_\_Divorced \_\_\_Widowed \_\_\_Separated \_\_\_Domestic Partner

Address: Street/Box: \_\_\_\_\_ Apt # \_\_\_\_\_

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

Home # (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_-\_\_\_\_

Best Contact Phone Number - Please Check One of the above numbers.

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

Preferred Pharmacy: \_\_\_\_\_

Location: \_\_\_\_\_

To communicate with us electronically please provide your **E-mail address**: \_\_\_\_\_

**POLICYHOLDER INFORMATION**

(if different than above)

Full Legal Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ M: \_\_\_\_\_

Address: Street/Box: \_\_\_\_\_ Apt # \_\_\_\_\_

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

Home # (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_-\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

**By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, we cannot alter your claim, change your diagnosis, or report a different service than what was performed so that your insurance will cover the charges.**

**EMERGENCY NOTIFICATION**

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

Home # (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_-\_\_\_\_