Patient Registration

Patient Information

Patient's Name: Last ___________________________ First _________________________Middle________________

Social Security #:______-_____-______ Male ______ Female ______ Date of Birth _______/_____/_______

Address: ____

City/State/Zip: ____ E-mail address: _________________________

Phone #: Daytime (____) _____-_________ Evening (____) _____-_________ Cell (____) _____-_________

Marital Status: ____ Divorced ____Married ____ Partner _____Single ____Widowed ___Legally Separated ____

Emergency Contact: _________________________ Phone: ______________ Relationship to patient: ___________

Insured Employer: __________________________________ Plant Location: _______________________________

Name of Pharmacy: ____Location: _____________________________

Primary physician to release reports to: _______________________________ Phone: _______________________

Living Will? Yes No _______ Advanced Directive? Yes _______ No ________

Power of Attorney? Yes ____ No Organ Donor? Yes No ____________

(Please provide a copy for chart)

Primary Insurance Information

Insurance Company Name: ____ Phone#: (___) _____-_______

Insurance Company Address: ____

Policy #: ____ Group #: _______________________________________

If patient is a MINOR, fill in responsible parent or guardian: (complete address if different from above)

Mother's Name:__________________________________Mother's Employer: _________________________ Mother's Date of Birth:__/_____/_Social Security #____-___-_____Work Phone: ____ Mother's address:____City/State/Zip _________

Father's Name:___________________________________Father's Employer: _____________________________ Father's Date of Birth:_____/____/__Social Security #____-____-______Work Phone: ____ Father's address:____City/State/Zip _________________________________

(Please provide your insurance card and a picture ID to the front desk at check- in)