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PATIENT REGISTRATION

NAME: _____ DOB: _____ AGE: _____ M / F _____ MARITAL STATUS
S M W D SEP
RACE
B H W OTHER

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: (HM) _____ (WK) _____ (CELL) _____

SSN #: _____ OCCUPATION/EMPLOYER: _____

SPOUSE/GUARDIAN NAME: _____ DOB: _____ PHONE: _____

SSN #: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: _____
(OTHER THAN SPOUSE) (NAME) (ADDRESS) (RELATIONSHIP)

REFERRED BY: _____ PHARMACY: _____

IF UNDER 18 (PARENT/GUARDIAN): _____ EMAIL ADDRESS: _____

CHIEF COMPLAINT: _____

INSURANCE & BILLING INFORMATION

MEDICARE #: _____ MEDICAID #: _____

BILLING NAME: _____ RELATIONSHIP: _____
(IF OTHER THAN PATIENT)

BILLING ADDRESS: _____ PHONE: _____
(IF DIFFERENT FROM ABOVE)

PRIMARY INSURANCE: _____

NAME OF INSURED: _____ RELATIONSHIP: _____

ID #: _____ GROUP #: _____

SECONDARY INSURANCE: _____

NAME OF INSURED: _____ RELATIONSHIP: _____

ID #: _____ GROUP #: _____

Do you have an Advanced Directive? Y / N

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

PAYMENT IS REQUIRED AT TIME OF SERVICE