Patient Registration

Name: ____ Date of Birth: _____ /______ /_______
FIRST MIDDLE LAST

Gender: ☐ Female ☐ Male ☐ Other: ____________________ *SSN: ____________________________________

Race: ______________ Ethnicity: ______________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address: ____ City: _________________ State: _____ Zip: _________

Home Address: ____ City: _________________ State: _____ Zip: _________

Home Phone: (_______) ________________ Work: (_______) _________________ Cell: (_______) _________________

May we leave messages from this office on your voicemail? ☐ Yes ☐ No

Email Address: ____

Emergency Phone: (_______) ____________ Name: _____________________________ Relationship: ________________

If patient is a child:
Who may authorize treatment for this child? ____
Relationship to Patient: ____________________________________ Phone: (_______) _________________
School Name: ____

How did you hear about us? ☐ Website ☐ Insurance Plan ☐ Phone Book ☐ Dr. _______________________
☐ Family/Friend (Name) ___________________________ ☐ Other____________________________

Preferred Pharmacy and Location (e.g. Costco on Dimond): ____

____ _______________________
Patient or Guardian Signature Date

PRIMARY INSURANCE *(Please provide card)*
Insurance Name: ___________________________________ Relationship to Subscriber: ____________________________
Subscriber's Name: ____ Subscriber's Date of Birth: _____ /______ /______
ID #: __________________________ Group #: _____________________ Subscriber's SSN: ___________________________

SECONDARY INSURANCE *(If applicable)*
Insurance Name: ____________________________________ Relationship to Subscriber: ___________________________
Subscriber's Name: ____ Subscriber's Date of Birth: _____ /______ /______
ID #:__________________________ Group #:______________________ Subscriber's SSN: ___________________________

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