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ADULT PATIENT REGISTRATION FORM

(Please Print)

Personal Information

Name: ______________________ Street Address: ______________________

City: __________ State: __________ ZIP: __________ Email: __________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Soc Sec #: __________ Sex: __________ Marital Status: __________ Date of Birth: __________

Your Employer: __________ Emergency Contact Name: __________

Emergency Contact Phone: __________ (Circle One) Home Cell Work Relationship to Patient: __________

Primary Care Physician: __________ PCP Phone: » __________

Preferred Retail Pharmacy (include location): ______________________

Preferred Mail Order Pharmacy: ______________________

Insurance Information

(All Insurance Cards Must Be Presented When Checking In For First Appointment)

Primary Carrier: ______________________

Subscriber or Contract #: __________ Group #: __________

Referral Authorization # (if required): __________ Co-Pay Amount (if any): $ __________

☐ I am the policy owner/main subscriber ***(skip info in box below if you are the policy owner/main subscriber)***

☐ I am covered under another person's policy Policyholder's Name: __________

Policyholder's Date of Birth: __________ Relationship to Patient: __________

Policyholder's Billing Address: ______________________

Secondary Carrier: ______________________

Subscriber or Contract #: __________ Group #: __________

Referral Authorization # (if required): __________ Co-Pay Amount (if any): $ __________

☐ I am the policy owner/main subscriber ***(skip info in box below if you are the policy owner/main subscriber)***

☐ I am covered under another person's policy Policyholder's Name: __________

Policyholder's Date of Birth: __________ Relationship to Patient: __________

Policyholder's Billing Address: ______________________