PATIENT REGISTRATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ GENDER:____ MARITAL STATUS: _____

RACE: _____ ETHNICITY: Not Hispanic or Latino / Hispanic or Latino **(circle one)**

ADDRESS_____ CITY: _____STATE/ZIP:_____

LANGUAGE: _____**How did you hear about us? _____**

CONTACT INFORMATION

HOME PHONE: _____CELL PHONE: _____

EMAIL: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ PHONE: _____ RELATIONSHIP:_____

EMPLOYMENT STATUS: EMPLOYED UNEMPLOYED STUDENT RETIRED

INSURANCE (S): *WE WILL MAKE A COPY* ***Guarantor Name and Date of Birth*: _____**

PRIMARY CARE (PCP):_____**LAST VISIT WITH PCP:**_____

PHARMACY INFORMATION

PHARMACY NAME:_____ **LOCATION:**_____

PLEASE PROVIDE US WITH A CURRENT MEDICATION LIST INCLUDING ALLERGIES

By signing below, I attest that the information provided above is true and accurate and give consent for evaluation and treatment of my condition.

Patient/Guarantor Signature: _____ Date: _____