



Registration Form

Patient Information					
Legal Last Name	Legal First Name	M.I.	Patient Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Primary Care Physician
Street Address		City		State	Zip
Mobile Number	Home Number (if applicable)	Preferred Pharmacy		Pharmacy Location	
Emergency Contact Name (Not living with you)		Relationship to patient		Emergency Contact Phone Number	
Preferred Communication <input type="checkbox"/> Text <input type="checkbox"/> Mobile <input type="checkbox"/> Email	Ethnicity	Race	Preferred Language		
Parent / Responsible Party Information					
Legal Last Name	Legal First Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN	
Preferred Name	Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other_____				Email
Street Address (If different than patient)		City		State	Zip
Mobile Number	Home Number (if applicable)	Preferred Communication (select one) <input type="checkbox"/> Text <input type="checkbox"/> Mobile <input type="checkbox"/> Email			
Responsible Party Employer		Occupation		Responsible Party Work Phone/Ext.	
Second Parent / Responsible Party Information					
Legal Last Name	Legal First Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN	
Preferred Name	Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other_____				Email
Street Address (If different than patient)		City		State	Zip
Mobile Number	Home Number (if applicable)	Preferred Communication (select one) <input type="checkbox"/> Text <input type="checkbox"/> Mobile <input type="checkbox"/> Email			
Responsible Party Employer		Occupation		Responsible Party Work Phone/Ext.	
Primary Insurance Information					
Insurance Company	ID (Policy Number)	Group Number	Copay \$	Effective Date	
Policy Holder Name	Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other_____				Policy Holder Date of Birth
Policy Holder Employer			Policy Holder SSN		
Secondary Insurance Information					
Insurance Company	ID (Policy Number)	Group Number	Copay \$	Effective Date	
Policy Holder Name	Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other_____				Policy Holder Date of Birth
Policy Holder Employer			Policy Holder SSN		

Authorized Signature _____ Date _____

Please bring this form along with your picture ID, insurance card(s) and applicable copay(s) to your appointment.