PATIENT REGISTRATION FORM

Last Name: _____First Name: _____ Sex: Male __ Female __

DOB: _____ Preferred Name: _____ SSN: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: _____ City: _____

State & Zip: _____ Cell Phone: _____

Home Phone: _____ Email: _____

Employment Status: ☐Full-Time ☐Part-Time ☐Unemployed ☐Student ☐Disabled ☐Retired

Employer: _____Occupation: _____

PHARMACY NAME & PHONE NUMBER: _____

PARENT OR GUARDIAN INFORMATION *(Only complete if patient is under the age of 18)*

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Preferred Name: _____ SSN: _____

Address: _____ City: _____

State & Zip: _____ Cell Phone: _____

Home Phone: _____ Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Home Phone: _____Cell Phone: _____ **MAY**

WE CONTACT YOU REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)?

☐No ☐Yes, by the above email.

☐No ☐Yes, by the above cell phone. Voicemail? ☐No ☐Yes Text? ☐No ☐ Yes

☐No ☐Yes, by the above home phone. Voicemail? ☐No ☐Yes

DO YOU WANT ANYONE TO HAVE ACCESS TO YOUR PHI? IF SO, WHO?

Name: _____ **Relationship to Patient:** _____

SIGNATURE: _____ **DATE:** _____

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