



## Patient Registration Form

Patient Name: \_\_\_\_\_  
Last Name First Name Middle

Address: \_\_\_\_\_  
Street or Box City State Zip

Phone: (Primary) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Gender:  Male  Female SS# \_\_\_\_\_

Marital Status:  Single  Married  Widow/Widower  Divorce

Employment Status:  Full Time  Part Time

Employer: \_\_\_\_\_

Student:  Full Time  Part Time  N/A

School: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Race:  American Indian or Alaskan Native  White  
 African-American  Hispanic  
 Asian  Native Hawaiian  
 Other: \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic Language Spoken: \_\_\_\_\_

Drivers License#: \_\_\_\_\_ State: \_\_\_\_\_

Referred By: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Name of Preferred Local Pharmacy: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_

How did you hear about us:  Newspaper Ad  TV/Radio Ad  Yellow Pages  
 Family/Friend Referral  Internet  Other \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

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### Please complete if PATIENT is a student or minor:

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_