

REGISTRATION FORM

PATIENT INFORMATION			
Patient's Name Last:	First:	MI:	Single / Married / Divorced / Widowed / Separated
Date of Birth:	Age	<input type="checkbox"/> M <input type="checkbox"/> F	Please provide patient's email if you would like access to the patient portal*:
Street address:			
State:	City:	Zip:	
Phone (Primary):		Phone (Secondary):	
Ethnicity: Hispanic or Latin / Non-Hispanic or Latin / Would like to not record			Primary Language:
Race: American Indian or Alaska Native / Asian / Native Hawaiian or other Pacific Black or African American / American White / Other _____			
INSURANCE INFORMATION			
Insurance Plan Name:			
Member #			
EMPLOYMENT INFORMATION			
Employer:		Occupation:	
PHARMACY PREFERENCE			
Pharmacy Name:		Phone:	
Street address:		City:	

I understand at least 3 business days notice must be given for prescription refills.

PATIENT/GUARDIAN/POA PLEASE SIGN: _____ DATE: _____

*Our patient portal is a secure online home for your medical office health information. It is designed to help you be a more active partner in your healthcare - in a convenient way.