REGISTRATION FORM

PATIENT INFORMATION				
Patient's Name Last: First: MI:				Single / Mar / Div / Sep /Wid
Date of Birth:	Age	❑ M ❑ F	Patient's Email:	
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 / Hispanic / 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:_____