 **Patient Registration**

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| **Name: ( ) Female**  **( ) Male** | | | **Date of Birth:** | |
| **Address:** | | | | |
| **City:** | **State:** | | **Zip:** | |
| **Cell Number:** | | **Home Number:** | | |
| **Email:** | | | | |
| **Preferred Pharmacy:** | | | **Pharmacy Address:** | |
| **Race:**  ☐ Asian ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown ☐ Decline to Answer | | **Ethnicity:**  ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Answer | | **Marital Status:**  ☐ Single ☐ Married ☐ Divorced  ☐ Widowed  ☐ Partnered  ☐ Decline to Answer |
| **Emergency Contact:** | | | | |
| **Relationship to Patient:** | | **Contact Number:** | | |
| **How did you hear about us?** | | | | |

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| **Insurance Information** | |
| **Insurance Company:** | **ID Number:** |
| **Name of Insured:** | **DOB (If different from above):** |
| **Address (If different from above):** | |
| **Secondary Insurance (If Applicable):** | |

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any remaining balance. I authorize Restoration Osteopathic Medicine to release any information required to process my claims.

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| **Patient/Guardian Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |