 **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** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |