

**\*\*Please review and update the information below to the best of your ability.\*\***

**Patient Registration**

<b>CURRENT PATIENT INFORMATION -- PLEASE PRINT</b>	<b>Guarantor Information (to whom statements are sent)</b>
Last Name:	Name:
First Name:	Address:
Middle Name:	Relationship to patient: _____
Address:	Date of Birth:
City: State:	Social Security No.:
Zip:	Phone: ( ) _____ - _____
Home Phone:	<b>Emergency Contact Information</b>
Work Phone:	Name:
Mobile Phone:	Relationship:
Sex:	Phone:
Date of Birth:	Mobile Phone:( ) _____ - _____
Social Security No.:	<b>Employer information</b>
Patient email:	Employer:
Required by government mandate [although you may refuse]:	Address:
Language:	Phone:
Race:	<b>Pharmacy Information:</b>
Ethnicity:	Name:
Marital Status:	Crossroads:
<b>Other</b>	Phone:
Patient Referred by:	
Primary Care Provider:	
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	

<b>Primary Insurance Information</b>	<b>Secondary Insurance Information</b>
Insurance Plan Name:	Insurance Plan Name:
Last Name:	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Date of Birth: Sex (please circle): <b>M</b> or <b>F</b>	Date of Birth: Sex (please circle): <b>M</b> or <b>F</b>
Employer Name:	Employer Name:
Patient's relationship to policy holder:	Patient's relationship to policy holder:

**To the best of my knowledge the above information is complete and accurate.**

**Signed** \_\_\_\_\_ **Date:** \_\_\_\_\_