New healthcare mandates require all Patient Registration information fields be completed:

PATIENT REGISTRATION

FIRST NAME: MI:	LAST NAME:	
STREET ADDRESS	ZIP CODE:	CITY:
HOME PHONE:	WORK PHONE:	CELL PHONE:
PHARMACY NAME & ADDRESS:	COPAY AMOUNT:	EMAIL ADDRESS:
HOW MANY INSURANCE PLANS?:	SEX: ( ) Male ( ) Female	DATE OF BIRTH:
RACE (check one): ( ) White ( ) Black/African American ( ) Native Hawaiian/Other Pacific Islander	( ) American Indian/Alaska Native ( ) Other	( ) Asian ( )Patient Declined/Unknown
SOCIAL SECURITY #:	PRIMARY DOCTOR:	
ETHNICITY: ( ) Spanish/Hispanic Origin ( ) Not of Hispanic Origin ( ) Patient Declined/Unknown	PRIMARY LANGUAGE: SECONDARY LANGUAGE:	COUNTRY: COUNTRY:

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:			
INS. COMPANY ADDRESS:	CITY:	STATE:	ZIP:
NAME OF INSURANCE POLICY HOLDER:	DATE OF BIRTH: SEX:	SOCIAL SECURITY #:	
INSURED'S POLICY #:	INSURED'S EMPLOYER:	EMPLOYER CITY/STATE/ZIP:	
INSURANCE GROUP#	PATIENT'S INSURANCE POLICY #:	EFFECTIVE DATE OF INSURANCE:	
RELATIONSHIP TO INSURED:	IF AUTO OR WORK RELATED,DATE OF INJURY:		

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME:			
INS. COMPANY ADDRESS:	CITY:	STATE:	ZIP:
NAME OF INSURANCE POLICY HOLDER:	DATE OF BIRTH: SEX:	SOCIAL SECURITY #:	
INSURED'S POLICY #:	INSURED'S EMPLOYER:	EMPLOYER CITY/STATE/ZIP:	
INSURANCE GROUP #:	PATIENT'S INSURANCE POLICY #:	EFFECTIVE DATE OF INSURANCE:	
RELATIONSHIP TO INSURED:	IF AUTO OR WORK RELATED,DATE OF INJURY:		

NAME (PRINT): _____

PRIVACY INFORMATION

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

OK TO LEAVE INFORMATION?

	Appointment Information:	Medical Information:
On home phone (Include Auto Call)?	**___Yes**	**___Yes**
On Cell Phone (Include Auto Call)?	**___Yes**	**___Yes**
On Office Voice Mail?	**___Yes**	**___Yes**
W/ another person?	**___Yes**	**___Yes**
Send via mail?	**___Yes**	**___Yes**
Send via e-mail?	**___Yes**	**___Yes**

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

Name: **Relationship:** **Phone:** **Cell Phone:**

_____

_____

_____

_____

Additional HIPAA Contact Instructions: _____

_____

_____

_____

Do we have your permission to obtain your medication history from the pharmacy? Yes No

Doctors or Facilities that participate in your healthcare (Name, Address, Phone and Fax #): _____

_____

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