Patient Registration Form

Patient Information:

Name (first and last): ____________________

Address: ____________________ City: ____________ State: _____ Zip: _______

Birthdate: ____________ Sex: _______ Home Phone: ____________

Social Security #: ____________ Email Address: ____________

Patient Lives With: Mother Father Both Other ____________

Race: (Circle One) American Indian Alaskan Native Native Hawaiian or Pacific African American White Hispanic or Other

Preferred Language: ____________________

Ethnicity: (Circle One) Hispanic or Latino Not Hispanic or Latino

Pharmacy Name: ____________ **Location** (cross streets): ____________

Mother's Information:

Name (first and last): ____________________ DOB: ____________

Address: ____________________ City: ____________ State: _____ Zip: _______

This person responsible for the bill?? (Circle One) Yes No

Social Security #: ____________ Home Phone: ____________ Cell Phone: ____________

Employer Name: ____________________ Work Phone: ____________

Father's Information:

Name (first and last): ____________________ DOB: ____________

Address: ____________________ City: ____________ State: _____ Zip: _______

This person responsible for the bill?? (Circle One) Yes No

Social Security #: ____________ Home Phone: ____________ Cell Phone: ____________

Employer Name: ____________________ Work Phone: ____________

Authorization for Treatment (other than parent(s) or guardian)

I give my consent and authorization for disclosure to the personal representatives I list below to have the right and privilege to request service or treatment for all minors listed on this form and obtain all medical information, should I not be present or available by telephone or otherwise.

Name: ____________ Phone: ____________ Relationship to Patient: ____________

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Privacy Notice

A notice of Privacy Practices (NPP) is available for your review or you may take it with you. The NPP describes our effort to protect the privacy of your personal health and financial information. The NPP also describes how such information may be used, released or shared under the Health Insurance Portability and Accountability ACT (HIPAA). Copies of the NPP are available upon request.

____
Parent/Guardian Signature

____
Date

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