Patient Registration Form

Patient Information

Name (first and last): _____

Address: _____ City: _____ State: _____ Zip: _____

Birth date: _____ Sex: _____ Home Phone: _____

Social Security #: _____ Email Address: _____

Patient Lives With: Mother Father Both Other: _____

Race: (Circle One) American Indian Alaskan Native Asian 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: _____

Is 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: _____

Is 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: _____

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

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 (HIPPA). Copies of the NPP are available upon request.

Parent/Guardian Signature: _____ Date: _____

Phone: 317-881-8737 / Fax: 317-881-8735 401 Camby Ct., Greenwood, IN 46142