Patient Registration Form

Patient Information

Name (first and last): ____

Address: ______________________ City: ______________ State: ______ Zip: __________

Date of Birth: ____________________ Sex: _________ Parents are (circle one): married / together / divorced / separated / other

Primary Contact Phone: ______________________ Email used for Portal: ______________________

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: ________

Does this person carry the insurance? (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: ________

Does this person carry the insurance? (Circle one) Yes No

Social Security #: ________________ Home Phone: ______________ Cell Phone: ________________

Employer Name: ______________________________ Work Phone: ________________

Authorization for Treatment

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.
If the patient is age 18+, please list your parents if you wish to share medical information with them.

Name: ____________________ Phone: ______________ Relationship to Patient: ______________

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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.

Signature: ______________________________ Date: ____________________

Relationship to Patient (Parent/Guardian/Self if 18+): ______________________________