Name:
Chart:
Date:

PATIENT REGISTRATION FORM

First Name	MI	Last Name		Sex

Home Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Preferred method of contact

Date of Birth	Age	Social Security Number	Marital Status	E-mail Address
			❑ S ❑ M ❑ D ❑ W	

Preferred Pharmacy Name, Address, and Phone

I agree that BRS and RGS may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Signature: _____ **Date:** _____

Race	Ethnicity	Preferred Language
☐ African American/Black ☐ Asian ☐ American Indian or Alaska Native ☐ White/Caucasian ☐ Native Hawaiian or other Pacific Islander ☐ Decline to provide	☐ Hispanic or Latino ☐ Non-Hispanic/Non-Latino ☐ Decline to provide	(please specify) _____

Patient Employer / Occupation (Indicate if student)	Financially Responsible Person	Name(if different from patient)
	❑Patient ❑Spouse ❑Parent ❑Other	

Financially responsible persons address (if different from patient)	Home phone	Work phone

Is patient residing in Skilled Nursing Facility? ❑ yes ❑ no	If yes, name and address of facility	Facility phone number

Emergency Contact	Relationship	Phone number

Referring Physician	Phone number

Primary Care Physician	Phone number

INSURANCE INFORMATION

Primary insurance:
Carrier: _____ **Address:** _____ **Phone:** _____
ID# _____ **Group#** _____ **Effective Date:** _____
Policyholder: _____ **Policyholder SSN:** _____ **DOB:** _____

Secondary Insurance:
Carrier: _____ **Address:** _____ **Phone:** _____
ID# _____ **Group#** _____ **Effective Date:** _____
Policyholder: _____ **Policyholder SSN:** _____ **DOB:** _____

Tertiary Insurance:
Carrier: _____ **Address:** _____ **Phone:** _____
ID# _____ **Group#** _____ **Effective Date:** _____
Policyholder: _____ **Policyholder SSN:** _____ **DOB:** _____