

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 <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	E-mail Address

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: \_\_\_\_\_

<b>Race</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Decline to provide	<b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Decline to provide	<b>Preferred Language</b> (please specify) _____
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Patient Employer / Occupation (Indicate if student)	Financially Responsible Person <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	Name (if different from patient)
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Financially responsible persons address (if different from patient)	Home phone	Work phone
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Is patient residing in Skilled Nursing Facility? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, name and address of facility	Facility phone number
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Emergency Contact	Relationship	Phone number
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Referring Physician	Phone number
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Primary Care Physician	Phone number
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**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: \_\_\_\_\_