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PATIENT REGISTRATION FORM

Full Name: ________________________________ Sex: ☐M ☐F Race _______________ Ethnicity: ☐Hispanic/Latino or ☐Non-Hispanic/Latino

Parent/Guardian Name (if minor): ____ Marital Status: ☐S ☐M ☐W

Address: ____ City: _____________________________ State: _____ Zip Code: __________

Social Security Number: ________ – ________ – _________ Date of Birth: _________________________ (mm/dd/yyyy) Age: ______

Home Phone: (   ) _______ – _________ Work Phone: (   ) _______ – _________ Cell Phone: (   ) _______ – _________

Employer: ____ Primary Care Physician: _____________________________________

Pharmacy Preference (include location): ____

Guarantor Name: ____________________________________ Guar. SSN: ________ – ________ – _________ Guar. DOB: ___________

Guar. Ph.: (   ) ________ – _________ Guar. Emp.: ____________________________ Guar. Occ.: ___________________________

Medications - List all medications currently being taken.

Name of Medication	Dosage (Required)	How Often Taken	Prescribing Physician

Medication Allergies - List any known medication allergies.

Name of Medication	Type of Reaction

Surgeries and Hospitalizations - List any surgeries and/or hospitalizations and the year of each.

Year	Type of Surgery/Hospitalization