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# PATIENT REGISTRATION

(PLEASE PRINT)

Name First Middle Last S S No.

Date of Birth Marital Status Select one Gender ☐ F ☐ M

Race Select one Ethnicity Select One Language

Address City State Zip

Home Phone Work No. Cell No.

Email Place of Work Occupation

Preferred Method Of Contact: ☐ Email ☐ Cell Phone ☐ Home Phone

Secondary Method Of Contact: ☐ Email ☐ Cell Phone ☐ Home Phone

Name of Your Preferred Pharmacy Phone Number

Who Were You Referred By

# INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD DURING REGISTRATION INS

INS Co Insurance ID # Group #

Policy Holder Relationship to Patient

DOB SS#

Policy Holder's Address

Place of Employment Phone

Secondary Insurance ☐ Yes ☐ No (if yes please complete required information)

INS Co Insurance ID # Group #

Policy Holder Relationship to Patient

DOB SS#

Policy Holder's Address

Place of Employment Phone

# EMERGENCY CONTACT

Name Relationship

Address

Best Contact No

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION: I hereby authorize release of medical information and direct payment to Dale Ann Dorsey, RNP-C or JeanAnn Schwark, FNP-C for services rendered in the course of my examination and/or treatment.

Date

Signature of Patient or Guardian