

PATIENT REGISTRATION

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

City: _____ State: Texas Other: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ Sex: Female Male

Social Security Number: _____

Marital Status: Single Married Divorced Widowed Other: _____

Spouse's Name: _____

Consent to send statements and appointment reminders by email: Yes No

E-mail address: _____

Preferred Pharmacy: _____ Location: _____

Do you have a physician? Yes No If yes, Physician's Name: _____

EMPLOYMENT INFORMATION

Employment Status: Full-time Part-time Unemployed Retired Self-employed Student

Employer: _____

Address: _____

City: _____ State: Texas Other: _____ Zip Code: _____

Work Phone: _____ Extension: _____

Guarantor or Card Holder Information:

Last Name: _____ First Name: _____ MI: _____

Relationship to patient: _____

Social Security Number: _____

Date of Birth: _____

Cell Phone: _____

Mailing Address if different from above: _____

City: _____ State: Texas Other: _____ Zip Code: _____

PAYMENT INFORMATION

Do you have Insurance? Yes No Are you a self-pay patient? Yes No

How did you locate us or get our phone number: Phonebook Internet Other: _____

Person to notify in case of emergency: _____

Relationship: _____ Phone Number: _____ Cell Home Other