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PATIENT REGISTRATION

NAME: _____ DOB: _____ AGE: _____ M / F _____ MARITAL STATUS
S M W D SEP
ADDRESS: _____ CITY/STATE/ZIP: _____ RACE
B H W OTHER
PHONE: (HM) _____ (WK) _____ (CELL) _____
SSN #: _____ OCCUPATION/EMPLOYER: _____

SPOUSE/GUARDIAN NAME: _____ DOB: _____ PHONE: _____
SSN #: _____ EMPLOYER: _____
(IF SPOUSE IS THE INSURED)

EMERGENCY CONTACT: _____ PHONE: _____
(OTHER THAN SPOUSE) (NAME) (RELATIONSHIP)

REFERRED BY: _____ PHARMACY: _____
(PLEASE SPECIFY WHICH LOCATION)

IF UNDER 18 (PARENT/GUARDIAN): _____

EMAIL ADDRESS: _____

Do you have an Advanced Directive? Y / N ****LIVING WILL****

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

PAYMENT IS REQUIRED AT TIME OF SERVICE