PATIENT REGISTRATION FORM

**All fields marked with an asterik must be completed*

Todays Date _____

Preferred Pharmacy _____

***Last Name:** _____

***First Name:** _____

Middle _____

Preferred Name _____

Maiden Name _____

***Date of Birth** _____

***Sex (please circle)** Female ☐ Male ☐ Unknown ☐ Other ☐

Social Security# _____

***Race (please circle)**
American Indian/Alaskan Native ☐ Nat/Hawaiian/Pacific Islander ☐
Asian ☐ Other Race ☐
Black/African American ☐ Unknown ☐
Declined ☐ White ☐

Marital Status(please circle) Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐

Drivers License # _____

***Primary Language** English ☐ Other, Please specify _____

Religion (please circle)
Buddhist ☐ Catholic ☐ Hindu ☐ Islam ☐ Jewish ☐
N/A ☐ Other ☐ Protestant ☐ Unknown ☐

***Ethnicity (please circle)**
Not Hispanic/Latino ☐ Unknown ☐
Hispanic/Latino ☐ Declined ☐

How were you referred:
Physician Referral ☐ IHPS Physician ☐
If physician, who referred? _____

Please Circle

Insurance ☐ Direct To Consumer ☐ Internet ☐

Established Patient ☐ Referred By A Patient ☐ Other ☐

PATIENT REGISTRATION FORM

NAME _____

***Address** _____

Zip _____

City _____

State _____

County _____

Country _____

Home Phone _____

Work Phone _____

Cell Phone _____

Best Contact Number _____

Preferred Communications Phone ☐ Cell Phone ☐ Mail ☐
Please Circle

Email Address: _____

Emergency Contact Person/Person to Contact

Name _____

Phone # _____

Alternate Phone # _____

Primary Care Physician _____

Signature: _____

Signature of Parent or Guardian (if a minor) _____

Date _____