TODAY'S DATE: _____

PATIENT REGISTRATION

PATIENT NAME (FIRST, MI, LAST)

DATE OF BIRTH | **M F OTHER** | **SSN (OPTIONAL)**

ADDRESS (STREET, CITY, ST, ZIP)

HOME PHONE | **CELL PHONE** | **WORK PHONE**

EMAIL ADDRESS

EMPLOYER/ADDRESS | **OCCUPATION**

PHARMACY (PRIMARY) | **SECONDARY** | **MAIL ORDER**

PRIMARY INSURANCE INFORMATION

INS COMPANY NAME | **COPAYMENT**

NAME/DOB OF SUBSCRIBER (IF PATIENT, ENTER "SELF") | **RELATIONSHIP**

SECONDARY INSURANCE INFORMATION (we do not take MassHealth)

INS COMPANY NAME | **COPAYMENT**

NAME/DOB OF SUBSCRIBER (IF PATIENT, ENTER "SELF") | **RELATIONSHIP**

DEMOGRAPHICS (this section is optional)

Please circle one or DECLINE ❑
Race: White African-American/Black Asian Native American Native Hawaiian

Please circle one or DECLINE ❑
English Irish European Chinese Korean Japanese Spanish/Hispanic

Primary Language Spoken: English Other _____ **DECLINE** ❑

PATIENT NAME/DOB: _____

TODAY'S DATE: _____

HIPAA PRIVACY INFORMATION

PLEASE SPECIFY WHERE WE MAY LEAVE MEDICAL AND APPOINTMENT INFORMATION (please check all that apply)**:**

Home Telephone / Answering Machine _____

Cellphone / Voice Mailbox _____

Mobile Text (appointment info only) _____

Work Telephone / Voice Mailbox _____

Regular Mail _____

Email / Portal _____

I allow my provider to discuss all aspects of my personal health information (PHI) with the person(s) listed below, unless specifically listed as an emergency contact only

NAME	RELATIONSHIP	PHONE	EMERG CONTACT ONLY