

REGISTRATION INFORMATION

(PLEASE PRINT)

Date: _____ Home Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birthdate: _____ Single Married Widowed Separated Divorced

Patient Employed by: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Spouse (or responsible party): _____

Business Address: _____

Occupation: _____ Business Phone: _____

Purpose of Visit: _____

Social Security #: _____

Name of Primary Care Physician: _____

Do you have medical insurance? No Yes

Name of Company: _____ Group # _____

Medicare Medi-Cal Other Ins. Claim ID # _____

In case of emergency, who should be notified? _____ Phone: _____

Your Drugstore Name: _____ Phone: _____

Signature of Patient _____