TODAY'S DATE: _____

PATIENT REGISTRATION

FIRST NAME:	MI:	LAST NAME:
DATE OF BIRTH:	SEX:	SSN (OPTIONAL):
STREET	CITY	STATE, ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE
EMAIL ADDRESS		
EMPLOYER / ADDRESS (CITY, STATE, ZIP)	OCCUPATION	
PHARMACY (PRIMARY)	PHARMACY (SECONDARY / MAILAWAY)	

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:	
NAME / DATE OF BIRTH OF SUBSCRIBER	RELATIONSHIP TO PATIENT
SUBSCRIBER'S EMPLOYER / ADDRESS (CITY, STATE, ZIP)	COPAYMENT:

SECONDARY INSURANCE INFORMATION (we do not take Mass Health)

SECONDARY INSURANCE COMPANY NAME:	
NAME / DATE OF BIRTH OF SUBSCRIBER	RELATIONSHIP TO PATIENT
SUBSCRIBER'S EMPLOYER / ADDRESS (CITY, STATE, ZIP)	COPAYMENT:

MOTOR VEHICLE OR WORKERS COMPENSATION INFORMATION

DATE OF INJURY / ACCIDENT:	CLAIM #
AUTO/WC INSURANCE COMPANY	ADDRESS (STREET, CITY STATE ZIP)
ADJUSTER CONTACT INFO (NAME, TELEPHONE, EXTENSION)	

TODAY'S DATE: _____

HIPAA PRIVACY INFORMATION

In order to comply with all federal regulations regarding your privacy in our office, we ask that you complete the following:

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

Home Telephone _____

Cellphone _____

Work Telephone/Voice Mail _____

With Another Person _____*(PLS LIST CONTACT INFO BELOW)

Through the mail _____

Via email _____

NAME	RELATIONSHIP	HOME &/or CELL PHONE	EMERG CONTACT?