HAKSHA
HEALTHCARE S.C

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# PATIENT REGISTRATION FORM

| Today's Date: | Drivers license #: | **Age:** | **Date of Birth:** |
|---|---|---|---|

| **Patient Name:** ( Last ) ( First ) ( Middle) | **Social Security #:** | Sex: ☐ Male ☐ Female |
|---|---|---|

**Billing Address:** Street / P.O. City State Zip

| **Home Phone** | **Cell Phone:** | Work Phone |
|---|---|---|

| **Email Address:** | **Ht:** | **Wt:** |
|---|---|---|

| Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other | Employment: ☐ Retired ☐ Full- Time ☐ Part-Time ☐ Unemployed ☐ Self Employed ☐ Military ☐ Homemaker |
|---|---|
| Primary Language: ☐ English ☐ Other:_____ | Living with: ☐ Alone ☐ Spouse ☐ Significant Other ☐ Family ☐ Friends |

| **Marital status:** | ☐ Single ☐ Married ☐ Male Partner ☐ Female Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married |
|---|---|

| Insured's Employer: | Contact Person: | Office Phone: |
|---|---|---|
| Employer Address: | | Fax Phone: |

## Guarantor/ Legal Guardian Information

| Emergency Contact Name: | Relationship | Primary Phone: |
|---|---|---|
| Address: | | Secondary Phone: |
| **Power of Attorney Name:** | | **Phone:** |

## Pharmacy Information

| Pharmacy Name: | Pharmacy Phone #: |
|---|---|
| Pharmacy Address: | |

## Insurance Information

### Primary Insurance

Co. Name:_____
Address: _____
City _____ State _____ Zip _____
Phone No: _____ Fax No: _____

Member ID#: _____Group #:_____
Insured Name: _____
Relationship: _____
SSN#:_____ DOB: _____

**INSURANCE COPAY: _____ DEDUCTIBLE: _____**

### Secondary Insurance

Co. Name:_____
Address: _____
City _____ State _____ Zip _____
Phone No: _____ Fax No: _____

Member ID#: _____Group #:_____
Insured Name: _____
Relationship: _____
SSN#:_____ DOB: _____

**INSURANCE COPAY: _____ DEDUCTIBLE: _____**