PATIENT REGISTRATION PROFILE

(For Office Use Only) Attending Physician_____ Patient ID#_____

Patient Name: _____
First Middle Last

Address: _____
Street Apt#

_____
City State Zip County

Primary Phone_____ Other Phone _____ Email _____

Date of Birth ____/_____/_____Social Security # _____-_____-_____ Gender: ☐ Male ☐ Female

Employer Name _____

Religious preference (optional)_____ ☐ N/A

Race: _____ Ethnicity: _____ Preferred Language: _____

Do you have any of the following Advance Directives: Living Will: Y or N DNR: Y or N Do you allow Blood Transfusions: Y or N

Emergency Contact: _____
Name Relationship Phone

Primary MD: _____ Referring MD: _____

Primary Insurance: _____ ID: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____/_____/_____ Social Security # _____-_____-_____

Secondary Insurance: _____ ID: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____/_____/_____ Social Security # _____-_____-_____

Guarantor (Person 18 years or older financially responsible – If different from patient)

☐ Guarantor same as patient

Patient Name: _____
First Middle Last

Address: _____
Street Apt#

_____
City State Zip County

Primary Phone_____ Other Phone _____ Email _____

Date of Birth ____/_____/_____Social Security # _____-_____-_____

cCARE is proud to announce we have a prescription dispensing program here on site, to better serve you. Please bring a copy of your prescription and insurance card. Should you have any questions, please feel free to ask upon arrival. Please indicate below an OUTSIDE pharmacy that you would conveniently use if outside dispensing is needed.

Outside Pharmacy Information:

Pharmacy Name: _____

Address/Cross streets: _____

Pharmacy Phone: _____

SIGNATURE: _____ **DATE:** _____ Rev 2017