Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	Address:
Middle Name:	
Address:	Relationship to patient: ________________________
City:	Date of Birth:
Zip:	Social Security No.:
Home Phone:	Phone: ( ) _______ - ______________
Work Phone:	**Emergency Contact Information**
Mobile Phone:	Name:
Sex:	Relationship:
Date of Birth:	Phone:
Mobile Phone:( ) _______ - ______________	
Patient email:	
Required by government mandate [although you may refuse]:	**Employer information**
Language:	Employer:
Race:	Address:

Ethnicity:	Phone:
Marital Status:	

Other	Pharmacy Information:
Patient Referred by:	Name:
Primary Care Provider:	Crossroads:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:

Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name:	Insurance Plan Name:
Patient's Member ID Number:	Patient's Member ID Number:
Policy Holder Last Name:	Policy Holder Last Name:
Policy Holder First Name:	Policy Holder First Name.:
Policy Holder Middle Name:	Policy Holder Middle Name:
Policy Holder Address:	Policy Holder Address:
City:	City:
Policy Holder Date of Birth: Policy Holder Sex (please circle): **M** or **F**	Policy Holder Date of Birth: Policy Holder Sex (please circle): **M** or **F**
Employer Name (if plan is through employer):	Employer Name (if plan is through employer):
Patient's relationship to policy holder:	Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed____

Date:________________________

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

Patient hereby authorizes HopeCentral, their employees and consultants, to perform diagnostic and treatment procedures. Patient understands that s/he will be involved and engaged in care and treatment. Patient understands that s/he has a right to consult with a physician prior to receiving a prescription drug or device order. If the patient requires specialized and/or emergency care, s/he will be referred to the appropriate medical facility or professional.

Signed____

Date:_________________________

I have read and understand the HIPAA/Privacy Policy for

Signed____

Date:_________________________

I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed____

Date:_________________________

I authorize to release medical information required to process my claim

Signed____

Date:_________________________

I have read and understand the Payment Policy for

Signed____

Date:_________________________

I authorize to obtain/have access to my medication history

Signed____

Date:___________________________________

I authorize my provider's office to contact me by mobile phone including text message and voicemail that may contain medical information

Signed____

Date:___________________________________