Patient Registration

marable
PERSONAL HEALTHCARE

PATIENT INFORMATION

Date: _____

Patient Name: _____ DOB: _____
Gender: O Male O Female
Home Address: _____
Email Address: _____
Phone #: Cell (____) ____ - _____ Home (____) ____ - _____ Work (____) ____ - _____
Preferred Pharmacy _____ Pharmacy # (____) ____ - _____

EMERGENCY CONTACT INFORMATION

Name: _____
Relationship: _____
Phone #: Cell (____) ____ - _____ Home (____) ____ - _____ Work (____) ____ - _____

INSURANCE INFORMATION
(Marable Personal Healthcare does not bill insurance for any services rendered, but we still need this information to assist with coordination of referrals, etc., when necessary)

* * * IMPORTANT * * *

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD. THIS INFORMATION IS USED TO ASSIST WITH SPECIALIST REFERRALS, LAB ORDERS, AND PRIOR AUTHORIZATION FOR PRESCRIPTIONS AND IMAGING STUDIES.