

REGISTRATION FORM

Pharmacy Name & Location: _____

Primary Doctor: _____

Referring Doctor: _____

Have you ever seen Dr. Pletcher? Yes No

Dr. Stouder? Yes No

Dr. Raymer? Yes No

Patient Information:

Patient Name: First _____ MI _____ Last _____

Address: _____ Soc. Sec. #: _____

City, State, Zip: _____ Gender: Female Male

May we contact you by email? Yes No If yes, email _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Marital Status: _____

Emergency Contact: _____ Phone#: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Member Name: _____ Member Name: _____

Health Savings Account? [Yes] [No]

Primary Card Holder's Information, if different than above:

Name: _____ Date of Birth: _____

Social Security#: _____ Home Phone: _____

Employer: _____ Work Phone: _____