PATIENT INFORMATION **(Please Print)**

Patient Registration Form

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) ___ Previous Name _____

Address _____ City, State _____ Zip _____

Home Phone _____ Cell # _____ Work Phone _____ Ext. _____

Family Doctor _____ Referring Doctor _____

Doctor you are seeing at this practice _____ Email Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M – Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1- Full time ☐ 2- Part time ☐ 3- Not Employed ☐ 4- Self Employed ☐ 5- Retired ☐ 6- Active Military

Student Status ☐ F – Full Time Student ☐ P – Part Time Student ☐ N- Not a Student

Emergency Contact: Last Name _____ First Name _____

Phone Number _____ Emergency Contact relationship to Patient _____

Address _____ City, State _____ Zip _____

Alternate Phone # _____ Do you have a living will? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION ***(information used for patient balance statements)***

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self Check here if information is same as patient ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____ /DD_____ /YYYY _____

Social Security Number _____-_____-_____ Telephone _____ Sex ☐ F- Female ☐ M- Male

E-mail Address _____

Address _____ City, State _____ Zip _____

Employer _____ Employer Phone # _____

PRIMARY INSURANCE INFORMATION ***(provide your insurance card to the front desk at check-in)***

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount $_____

Effective Date _____ Date of Birth MM_____/DD_____/YYYY_____

SECONDARY INSURANCE INFORMATION ***(provide your insurance card to the front desk at check-in)***

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount $_____

Effective Date _____ Date of Birth MM_____/DD_____/YYYY_____

***** I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.**

***** Patient (or Responsible Party) Signature _____ Date _____**