# Patient Registration Form

## PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

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

Address _____ City, State _____ Zip _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext _____

Primary Care Provider (PCP) _____ Referring Provider _____

Date of Birth MM _____, DD _____, YYYY _____ Sex ☐ Female ☐ Male

Race ☐ Asian Indian ☐ Asian Pacific Islander Hawaiian ☐ Black African American
☐ Hispanic African American Ancestry ☐ Hispanic Caucasian ☐ Hispanic Other Latino
☐ Multiracial ☐ White Caucasian ☐ Other ☐ Unknown

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Refused ☐ Unknown

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian
☐ Other _____

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

Religion _____ E-Mail Address _____

Social Security Number _____-_____-_____ Employer Name _____

Employer Phone _____ Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed
☐ Self Employed ☐ Disabled ☐ Retired ☐ Active Military
☐ Student - Full Time ☐ Student - Part Time

## EMERGENCY CONTACT INFORMATION

Last Name _____ First Name _____ Relation to Patient _____

Phone _____ Cell Phone _____ Work Phone _____ ☐ Guardian

Address _____ City, State _____ Zip _____

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

Last Name _____ First Name _____ Relation to Patient _____

Date of Birth MM _____, DD _____, YYYY _____ Sex ☐ Female ☐ Male

Social Security Number _____-_____-_____ Employer Name _____

Employer Phone _____ Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed
☐ Self Employed ☐ Disabled ☐ Retired ☐ Active Military
☐ Student - Full Time ☐ Student - Part Time

Address _____ City, State _____ Zip _____

## PRIMARY INSURANCE INFORMATION

Insurance Company _____ Phone _____

Name of Insured _____ Relation to Patient _____

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

Effective Date _____ Termination Date _____ Date of Birth MM _____, DD ____, YYYY _____

## SECONDARY INSURANCE INFORMATION

Insurance Company _____ Phone _____

Name of Insured _____ Relation to Patient _____

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

Effective Date _____ Termination Date _____ Date of Birth MM _____, DD ____, YYYY _____