Patient Registration Form

PATIENT INFORMATION (Please Print)

❑Dr. ❑Miss ❑Mr. ❑Mrs. ❑Ms. ❑Sir

Patient's Name (Last) ______ (First) ______ (MI) ______ Previous Name ______

Address Line 1 ______ 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 Line 1 ______ 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______