PATIENT REGISTRATION

PATIENT INFORMATION

☐Dr. ☐Miss ☐Mrs. ☐Ms. ☐Sir

Patient's Name: (Last)_____ (First)_____ (MI)_____ Previous Name_____

Address Line 1: _____

City, State Zip: _____

Home Phone: _____ **Cell Number:** _____ **Work Phone:** _____

Primary Care Provider (PCP): _____ **Referring Provider:** _____

Pharmacy Number: _____ **E-mail Address:** _____

Date of Birth: _____ **Sex: ☐Female ☐ Male ☐ Transgender**

Race: ☐American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ African American ☐ White ☐ Other **Ethnicity:** ☐ Hispanic or Latino ☐ Non- Hispanic or Latino ☐ Declined

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

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

Social Security Number: _____ **Employer Name** _____

Emergency Contact: _____

Emergency Contact Relationship to Patient: _____

Address Emergency Contact: _____

City, State Zip: _____ **Home Phone:** _____

Cell Phone: _____ **Work Phone:** _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐ Another Patient ☐ Guarantor ☐ Self

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

Date of Birth: _____ **Social Security number**: _____

Address: _____

City, State Zip: _____

Employer: _____ **Employer Phone Number:** _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ **Phone:** _____

Name of Insured: _____ **Patient Relationship to insured:** _____

Date of Birth: _____

Subscriber ID (policy number): _____ **Group #:** _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ **Phone:** _____

Name of Insured: _____ **Patient Relationship to insured:** _____

Date of Birth: _____

Subscriber ID (policy number): _____ **Group #:** _____

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:** _____