confidential

PATIENT REGISTRATION

Today's DATE: ___/___/___

How did you hear about us: News Paper ☐ AD ☐ Health Dept. ☐ TV AD ☐ Friend / Relative ☐ Bill-Board ☐ Other: _____

Patient Name _____ (last name / first name / middle initial)

e-mail Address: _____

Can we e-mail you for: Appointment: ☐ Yes ☐ No Marketing: ☐ Yes ☐ No

Social Security #: ___ — ___ — ____ Date of Birth: ___/___/___ Sex: ☐ M ☐ F ☐ Minor

Drivers License #: _____ _____ Age

Address: _____

_____ (city / state / zip code)

Home Phone: ( ) —

Work Phone: ( ) —

Cell Phone: ( ) —

School Phone: ( ) —

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated ☐ Partnered for _____ years

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

Ethnic: ☐ Hispanic or Latino ☐ Non-Latino Seasonal / Migrant Worker: ☐ Yes ☐ No

Veteran: ☐ Yes ☐ NO Religion: _____ (optional) Occupation: _____

Patient Employer/School: _____

Best Time and Place to Reach You: _____

Employer/School Address _____ (city / state / zip code)

Spouse

Spouse's Name _____ (last name / first name / middle initial)

Social Security #: ___ — ___ — ____ Date of Birth: ___/___/___

Spouse's Employer _____

Minor

Guardian/Custodial Parent Name: _____ (last name / first name / middle initial)

Guardian/Custodial Parent Address: _____

_____ (city / state / zip code)

Home Phone: ( ) —

Cell Phone: ( ) —

Work Phone: ( ) —

Emergency

Contact: Name _____ (last name / first name / middle initial)

Home Phone: ( ) —

Cell Phone: ( ) —

Work Phone: ( ) —

Primary Insurance

Person responsible for Account: _____ (last name / first name / middle initial) Date of Birth: ___/___/___

Relatationship to this person: _____ Work Phone: ( )

Primary Employed by: _____ Soc. Sec. #: ___ — ___ — ____

Insurance Company: _____ ID Number: _____ Group #: _____

Additional Insurance

Person responsible for Account: _____ (last name / first name / middle initial) Relatationship to this person: _____

Primary Employed by: _____ Soc. Sec. #: ___ — ___ — ____ Work Phone: ( ) —

Insurance Company: _____ ID Number: _____ Group Number: _____

I understand I am responsible for any unpaid services that are not covered through my insurance. Signature of patient: _____