

REGISTRATION FORM

Please Print Clearly

Date Completed: _____ Form Completed By: _____

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ Middle: _____

Alias/ Nickname: _____

Social Security #: _____ Gender: _____ Date of Birth: _____ Age: _____

Permanent / Physical Address (Required) – *If PO Box is used for mailing please list as Confidential Address*

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Temporary Address **Confidential Address** (Not Required) Start Date: _____ End Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Contact Phone Numbers: Home: _____ Work: _____

Cell / Mobile: _____ Email: _____

GENERAL INFORMATION

Interpreter Needed? Yes No Preferred Language: _____

Marital Status: _____ Spouse's Name: _____

Religion: _____

Hispanic / Latino Ethnicity? Yes NO Country of Birth: _____

Check all Race Categories the patient self-identifies as:

American Indian / Alaskan Native

Native Hawaiian or Other Pacific Islander

Asian

White / Caucasian

Black or African American

Declined to Answer

REFERRING PHYSICIAN

Name: _____ Phone Number: _____

Location: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone Number: _____

Location: _____

Approximate start date of care: _____

REGISTRATION FORM

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EMPLOYMENT STATUS (Please Check One)

Employed: Full Time Part Time Self Employed Active Military

Occupation: _____ Employer: _____

Address: _____

Student : Full Time Part Time

Retired: (Date) _____ Company: _____

Disabled: (Date) _____

EMERGENCY CONTACTS

Contact #1 Name: _____ Relationship: _____

Home: _____ Work: _____ Cell / Mobile: _____

Contact #2 Name: _____ Relationship: _____

Home: _____ Work: _____ Cell / Mobile: _____

GUARANTOR OF ACCOUNT (required if patient is a minor)

Mother Father Legal Guardian Other _____

Last Name: _____ First Name: _____ Middle: _____

Alias/ Nickname: _____

Social Security #: _____ Gender: _____ Date of Birth: _____ Age: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____ Relationship to Patient: _____

Date of Birth: _____ SS# _____ Employer: _____

Patient Policy #: _____ Subscriber Policy #: _____

Group # (if applicable) _____

Secondary Insurance: _____

Subscriber's Name: _____ Relationship to Patient: _____

Date of Birth: _____ SS# _____ Employer: _____

Patient Policy #: _____ Subscriber Policy #: _____

Group # (if applicable) _____