PATIENT REGISTRATION FORM

Today's Date ________________________________

PATIENT INFORMATION

Patient Last Name	First	Middle	Salutation ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Sep ☐ Widow
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Birthdate	Age	Sex ☐ Male ☐ Female ☐ Trans
Street or Mailing Address (circle one)	City	State	Zip Code	Home Phone Number
Cell Phone Number	E-Mail Address (to be used for appointment reminders)		Social Security Number	
Occupation	Employer		Employer Phone Number	

Employment Status: ☐ 1-Full-Time ☐ 2-Part-Time ☐ 3-Not Employed ☐ 4-Self-Employed ☐ 5-Retired ☐ 6-Active Military

Student Status: ☐ F-Full-Time Student ☐ P-Part-Time Student ☐ N-Not a Student

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

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

Pharmacy: | Do you have a living will? ☐ Yes ☐ No

Referred by (please check one box): ☐ Dr. ___________________________ ☐ Insurance ☐ Hospital ☐ Family ☐ Friend ☐ Yellow Pages ☐ Internet Search/Website ☐ Other ____

Other family members seen here:

Primary Care Physician Name: | Phone number:

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party: ☐ Another Patient ☐ Guarantor ☐ Self | ☐ Check here if information is same as patient

Name	Address		Home Phone Number
Birth Date	E-Mail Address		
Occupation	Employer	Employer Address	Employer Phone Number

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ☐ Worker's Compensation (WC) ☐ Occupational Medicine (OM) ☐ Motor Vehicle Accident (MVA) ☐ Accident Date ____

Does the patient have healthcare coverage? ☐ Yes ☐ No | Insurance Name:

Name of Insured	Social Security Number	Birth Date	Effective Date	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____

Name of Secondary Insurance	Name of Insured	Date of Birth	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number	Other Phone Number

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text message and/or email message from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and consent to any services that are appropriate for my care and as ordered by my physician(s).

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Patient/Guardian Signature Date