



Patient Registration Form

Last Name _____ First Name _____ MI _____

AKA (Also Known As) /Previous Last Name(s) _____

Social Security # _____ - _____ - _____ Date of Birth _____ / _____ / _____ Gender: Male Female

Marital Status: Married Single Divorced Legally Separated Widowed Life Partner

Home Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____

Cell Phone (____) _____

Alternate Phone (____) _____

Alternate Phone Info _____

E-Mail _____

Preferred Method of Communication: Home Phone Cell Phone Alt Phone E-Mail Text

Primary Care Physician/Pediatrician _____

If pediatric patient, please list siblings _____

Race: White Black or African American American Indian or Alaska Native Asian Pacific Islander or Native Hawaiian Other Race- Please Print _____

Ethnicity: Hispanic or Latino or Spanish Origin Not Hispanic or Latino or Spanish Origin Other/Unknown – Please Print if Other _____

Language Preference: If other than English- Please Print _____

Do you have a Hearing or Vision Impairment that requires assistance for Effective Communication?

If yes, please check appropriate item(s): Vision Hearing

Patient's Employer _____

Address _____

City _____ State _____ Zip Code _____

Work Phone Number (____) _____ Ext _____

Person Financially Responsible for Bill after Insurance Payment is received (Complete only if Patient is not responsible)

Are you the patients Guarantor? Legal Guardian?

Guarantor/Legal Guardian Name _____ Social Security # _____ - _____ - _____

Patient's Relationship to Guarantor/Legal Guardian: Spouse Dependent Child Student

Date of Birth _____ / _____ / _____ Other – Please Print _____

Guarantor/Legal Guardian Home Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Guarantor/Legal Guardian Employer Name & Address _____

City _____ State _____ Zip Code _____

Emergency Contact - Who to call in the event of an Emergency

1. Name _____ Relationship _____

Cell/Hm Phone # (____) _____ Work Phone# (____) _____

2. Name _____ Relationship _____

Cell/Hm Phone # (____) _____ Work Phone # (____) _____

Is your visit due to a job related injury or automobile accident? Yes No

Do you have an Advance Care Plan? (Advance Directive, Living Will, Medical Power of Attorney) Yes No

Does the patient have insurance? Yes No

Primary Insurance Information - Please complete the below information if the patient is not the Policy Holder for the Primary Insurance

Plan Name _____

Policy Holder's Name _____ Gender: Male Female

Policy Holder's # _____ - _____ - _____ Policy Holder's Date of Birth ____/____/____

Secondary Insurance Information - Please complete the below information if the patient is not the Policy Holder for the Secondary Insurance

Plan Name _____

Policy Holder's Name _____ Gender: Male Female

Policy Holder's # _____ - _____ - _____ Policy Holder's Date of Birth ____/____/____

Patient/Guarantor Printed Name _____ **Patient DOB** ____/____/____

Patient/Guarantor Signature _____ **Date** ____/____/____