PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name _____ First _____ MI _____ Nickname _____

Address: Street _____ City _____ State _____ Zip Code _____

Phone w/area code: _____ **Cell**: _____ **Work**:_____

DOB: _____ Age: _____ **SS #** _____ **Email Address**: _____

Sex: ☐ Male ☐ Female

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

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Multi-racial ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language:_____

If married, spouses name: _____ **DOB:** _____ Phone # _____

Emergency Contact: _____

Relationship: _____ **Phone #** _____

ADVANCED DIRECTIVE: Do you have a living will? _____ Healthcare Power of Attorney?_____

If Yes, Contact Person:_____ Relation: _____ Phone: _____

Primary Pharmacy:_____ **Address**: _____ **Phone**: _____

Primary Care Physician: _____ **Address**: _____ **Phone**: _____

Referring Physician: _____ **Address**: _____ **Phone**: _____

Employer: _____ Occupation:_____

Employer address: _____ Employer Phone:_____

Person responsible for bill, if other than patient: _____ **DOB**: _____

Address: _____ Phone: _____

SS# _____ **Relationship**: _____

INSURANCE INFORMATION:

Primary Insurance:_____ Policy # _____ Group # _____

Policy Holder:_____ **SS #** _____ **DOB:** _____

Secondary Insurance: _____ Policy # _____ Group # _____

Policy Holder: _____ **SS #** _____ **DOB:** _____

Please list any person(s) that is able to obtain medical information on your behalf:

Name: Phone Number:

_____ _____

_____ _____

_____ _____

Patient Name:
Signature

_____