PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name ____________________ Social Security ____________

Address ____________________

City, State, Zip ____________________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Email ____________ Marital Status ____________ Gender: ❑ Female ❑ Male

Date of Birth ____________ Preferred Contact: ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Email

EMERGENCY CONTACT/OTHER INFORMATION

Emergency Contact ____________________ Relationship to Patient ____________

Emergency Contact Phone(s) ____________________

Preferred Language ____________________

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

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Referring Physician ____________________ Primary Care Physician ____________________

PRIMARY HEALTH INSURANCE INFORMATION

Primary Insurance ____________________

Insured Name ____________________ Relationship to Patient ____________

Insured Date of Birth ____________ Insured Gender ____________ Insured SSN ____________

Insured Group Number ____________________ Insured ID Number ____________________

SECONDARY HEALTH INSURANCE INFORMATION: Do you have Secondary Insurance? ❑ Yes ❑ No

Secondary Insurance ____________________

Insured Name ____________________ Relationship to Patient ____________

Insured Date of Birth ____________ Insured Gender ____________ Insured SSN ____________

Insured Group Number ____________________ Insured ID Number ____________________

GRANTOR/RESPONSIBLE PARTY INFORMATION

Responsible Party ____________________ Relationship to Patient ____________

Responsible Party Address ____________________

City, State, Zip ____________________

Responsible Party Home Phone ____________________ Responsible Party Date of Birth ____________________