Patient Registration

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix): ____________ Nickname: ____________ **Sex:** ❑ Male ❑ Female

Date of birth ____________ **Social security number** ____________ **Race** ____________ **Preferred language** ____________

Ethnicity: ❑ Hispanic ❑ Non-Hispanic **Marital status**: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Life partner

Complete mailing address:____________
(Street, city, state, zip code, county)

Home phone number:____________ **Cell phone number**:____________ **Work number**:____________

Email:____________

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date:____________

Employer name:____________ **Employer phone number**:____________

Employer complete address:____________
(Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ❑ **Same as patient**

Full legal name (First, Middle, Last, suffix) ____________ **Date of birth** ____________ **Social security number** ____________

Relation to patient: ❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other:____________ **Sex**: ❑ Male ❑ Female

Home phone number:____________ **Cell phone number**:____________ **Work number**:____________

Complete mailing address – if different from patient:____________
(Street, city, state, zip code, county)

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date:____________

Employer name:____________ **Employer phone number**:____________

Employer complete address:____________
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last):____________

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other:____________

Home phone number:____________ **Cell phone number**:____________ **Work number**:____________

Complete mailing address – if different from patient:____________

INSURANCE INFORMATION ❑ **Self-pay (no insurance)**

Primary insurance:____________ **Patient relation to subscriber**: ❑ Self ❑ Spouse ❑ Child ❑ Other:____________

Secondary insurance:____________ **Patient relation to subscriber**: ❑ Self ❑ Spouse ❑ Child ❑ Other:____________

Prescription/Rx provider:____________ **(if different from insurance carrier)**

Full name of subscriber:____________ **(complete below if different from patient, spouse or guarantor)**

Subscriber date of birth:____________

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date:____________

Employer name:____________ **Employer size**: ❑ 0 – 19 employees ❑ 20 – 99 ❑ 100+

Employer complete address:____________
(Street, city, state, zip code)

Primary care physician:	**Do you want anyone to know you are here?** ❑ **Yes or** ❑ **No**