

**Patient Registration Form**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

AKA (Also Known As) /Previous Last Name(s) \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  FemaleMarital 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 \_\_\_\_\_

Patient/Family 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  StudentDate 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 \_\_\_\_\_

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**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 #(\_\_\_\_\_) \_\_\_\_\_

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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

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**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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Patient/Guarantor Printed Name** \_\_\_\_\_

**Patient/Guarantor Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_