

**Patient Registration Form (Page 1)**

**Patient Information:**

|  |  |  |
| --- | --- | --- |
| Last Name: | First Name:  M.I.: | SSN: |
| Sex: | Preferred Gender: | Birth Date: |
| Mailing Address: | | |
| City: | State: | Zip: |

**Responsible Party:   
If the patient is a minor, the parent or guardian bringing the patient in will be listed as the guarantor**

|  |  |  |
| --- | --- | --- |
| Last Name: | First Name:       M.I.: | SSN: |
| Sex: | Preferred Gender: | Birth Date: |
| Relationship to Patient: | | |
| Mailing Address of Person Responsible: | | |
| City: | State: | Zip: |

**Contact Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Home Phone: | | Mobile Phone: | Work Phone: |
| Email: | | | |
| Emergency Contact Phone #: | Emergency Contact Name: | | |
| Emergency Contact Relationship to Patient: | | | |



**Patient Registration Form (Page 2)**

**General Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Interpreter Needed? | Preferred Language: | | |
| Marital Status: | | | |
| Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Decline | | Race:  White  Hispanic  Other  American Indian  or Alaska Native | Black or African American  Asian  Native Hawaiian or Pacific Islander  Decline |

**Insurance Information:**

|  |  |
| --- | --- |
| Primary Medical Insurance | Secondary Medical Insurance |
| Ins. Co. Name: | Ins. Co. Name: |
| Policy Holder Name: | Policy Holder Name: |
| Policy Holder’s Date of Birth:       Sex:      Employer:       Occupation: | Policy Holder’s Date of Birth:      Sex:      Employer:      Occupation: |
| Policy Holder’s SSN: | Policy Holder’s SSN: |
| Patient Relationship to Policy Holder: | Patient Relationship to Policy Holder: |