

**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:      |