Today's Date _____/_____/_____

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

| Patient Name Last | First | Middle | □ Mr □ Mrs □ Miss □ Ms | Marital Status (circle) Single/ Married / Divorced /Sep/ Widow |
|---|---|---|---|---|
| Is this your legal name? □ YES □ NO | If not, what is your legal name? | | Birthdate / / | Age Sex □ M □ F □ T |
| Street or Mailing Address (circle one) | City | State | Zip Code | Home Phone Number ( ) |
| Cell Phone Number ( ) | E-Mail Address | | | Social Security - - |
| Occupation | Employer | | Employer Phone Number | |

**Employment Status:** □1 – Full-Time □2 – Part-Time □3 – Not Employed □4 – Self-Employed □5 – Retired □6 – Active Military

**Student Status:** □F – Full-Time Student □P – Part-Time Student □N – Not a Student

**Race:** □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

**Ethnicity:** □Hispanic or Latino □Not Hispanic or Latino □Declined

**Language:** □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other _____

**Pharmacy:** Do you have a living will? □ YES □ NO

Referred By ( Please check one box)

□ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other _____

Other Family Members Seen Here

PCP Name Phone #

## RESPONSIBLE PARTY INFORMATION

Responsible Party: □Another Patient □Guarantor □Self □Check here if information is same as patient

| Name | Address | Home Phone Number |
|---|---|---|
| Birth Date / / | E-Mail Address | ( ) |
| Occupation / Employer | Employer Address | Employer Phone Number ( ) |

## INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)

□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE _____

Does the patient have healthcare coverage? □ YES □ NO **Insurance Name**

| Name of Insured | Social Security Number | Birth Date | Effective Date | Group ID | Subscriber ID (Policy Number) |
|---|---|---|---|---|---|
| | - - | / / | / / | | |

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

| Name of Secondary Insurance | Name of Insured | Date of Birth | Group ID | Subscriber ID (Policy Number) |
|---|---|---|---|---|
| | | / / | | |

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

## EMERGENCY CONTACT

| Name (Last, First) | Relationship to Patient | Home Phone Number | Other Phone Number |
|---|---|---|---|
| | | ( ) | ( ) |

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient/ Guardian Signature Date