Date:

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES			
PATIENT NAME (LAST--FIRST--MIDDLE INITIAL)	**ADDRESS**		
CITY, STATE **ZIP**	**HOME PHONE**	**CELL PHONE**	
SECOND PHONE	**DATE OF BIRTH**	**MARITAL STATUS** ☐ Single ☐ Married ☐ Other	
Email:	**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report	**Language:** ☐ English ☐ Spanish ☐ Other, please list below	**Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Pacific Islander ☐ Other Race ☐ Unreported/Refused to Report
PATIENT EMPLOYER NAME	**PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY -STATE - ZIP)**	**EMPLOYER PHONE**	

INSURED/RESPONSIBLE PARTY INFORMATION	RELATION TO PATIENT: ☐spouse ☐parent ☐guardian			
NAME (FIRST -- LAST -- MIDDLE INITIAL)	**ADDRESS (If different from patient)**			
HOME PHONE	**WORK PHONE**	**SSN**	**BIRTH DATE**	**EMPLOYER**

INSURANCE INFORMATION			
PRIMARY INSURANCE NAME	**ADDRESS (STREET - CITY - STATE - ZIP)**		**PHONE**
GROUP NUMBER	**SUBSCRIBER/ID NUMBER**	**EMPLOYER**	**EMPLOYER PHONE**
SECONDARY INSURANCE NAME	**ADDRESS (STREET - CITY - STATE - ZIP)**		**PHONE**
GROUP NUMBER	**SUBSCRIBER/ID NUMBER**	**EMPLOYER**	**EMPLOYER PHONE**

PRIMARY DOCTOR/FAMILY DOCTOR	**REFERRING DOCTOR**	
IN CASE OF EMERGENCY CONTACT:	**RELATIONSHIP**	**PHONE NUMBER**
Does the above mentioned emergency contact have permission to discuss your protected health information: Yes__No_____		