Patient Registration Form

NAME (Last, First, Middle)	Social Security Number	Date of Birth
Address	City, State, Zip Code	

Home Phone	Daytime Phone	Cell Phone	Work Number
Marital Status	Student Status (FT/PT)	Smoker? (Y or N)	Email address

Primary Care Physician

Referring Physician

To comply with Government reporting, Please circle which applies:

Race: Asian Caucasian American Indian /Alaskan Native Black/African Hispanic Hawaiian/ Pacific Islander Other Race Refused to report

Primary Language spoken: English Spanish Refuse to report Other

Ethnicity: Hispanic Non-Hispanic Refuse to report

Primary Insurance Card MUST be provided at time of service

Primary Employer (Patient)	Emergency Contact Name and Relation
Address	Emergency Contact Phone
City, State, Zip Code	Emergency Contact Address

Responsible Party Information – If different than self/patient (Who is the insurance carrier)

NAME Last, First, Middle	Address (if different)
Social Security Number	Date of Birth
Cell Phone	Relationship to Patient (ie. Parent, Spouse, etc.)

How did you hear about our practice: ☐ Friend or relative ☐ Newspaper Ad ☐ Insurance Company ☐ Physician Referral ☐ Billboard

Who may we thank for the referral? ______________________________

Signature of Patient/Guardian ______________________________ Date: ______________