Patient Registration

Patient Information				
Name (First, Middle, Last)	Birth Date	Age	Social Security #	Gender
Mailing Address	Apt#	City, State, ZIP		
Email Address		Primary Phone		Ok to leave message? □ Yes □ No
Employer (parent/guardian if patient is a minor)			Work Phone	Marital Status
Primary Care Provider (where you go for your routine medical care)				

To Comply with government reporting, please check which applies:	
Preferred Language □ English □ Spanish □ Other	Race: □ Black or African American □ Asian □ Caucasian □ American Indian/Alaskan Native □ Native Hawaiian/Other Pacific Islander □ Other □ Refuse to report
Ethnicity □ Hispanic □ Non-Hispanic □ Refuse to report	

Emergency Contact		
Contact Name	Phone Number	Relationship to Patient

Medical Insurance (please present your ID and insurance card at check-in)			
Primary Insurance Company Name	Policy #/Member ID		Group #
Guarantor Name (who is the insurance carrier)	Guarantor Date of Birth	Patient Relationship to Guarantor	
Secondary Insurance Company Name	Policy #/Member ID		Group #
Guarantor Name (who is the insurance carrier)	Guarantor Date of Birth	Patient Relationship to Guarantor	

How did you hear about us?
□ Friend or Relative □ Newspaper Ad □ Insurance Company □ Physician Referral □ Billboard Who may we thank for the referral?

Patient/Guardian Signature	Date