

PATIENT REGISTRATION FORM

PLEASE PROVIDE DRIVER'S LICENSE AND INSURANCE CARDS FOR COPY.

PATIENT INFORMATION:

Legal Name: _____ Maiden Name: _____
Social Security Number: _____ Date of Birth: _____ Age: _____ Male Female
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ Cell: _____ Work: _____
Email Address: _____ *(We will not share this with other entities or send confidential information via email.)*
Race: American Indian or Alaska Native Asian Black or African American **Ethnicity** Hispanic or Latino
 Native Hawaiian or Pacific Islander White Other _____ Non-Hispanic or Latino
Preferred Language: English Spanish French Chinese Other
Marital Status: Married Single Divorced Widow Minor Separated
Employer: _____ Employer's Phone: _____
City: _____ St: _____ Zip: _____

RESPONSIBLE PARTY (GUARANTOR) FOR CHARGES NOT PAID BY INSURANCE:

Guarantor's Name: _____ Relationship to patient: _____
SS #: _____ Date of Birth: _____
Address: _____ City: _____ St: _____ Zip: _____
Phone: _____ Employer: _____
Address: _____ City/St: _____ Zip: _____
Race: American Indian or Alaska Native Asian Black or African American **Ethnicity** Hispanic or Latino
 Native Hawaiian or Pacific Islander White Other _____ Non-Hispanic or Latino
Preferred Language: English Spanish French Chinese Other

Emergency Contact :

Name: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name: _____ Policyholder: _____ Date of Birth: _____ SS#: _____ Address: _____ City/St/Zip: _____ Employer: _____ Relationship to Patient: _____ Effective Date of Coverage: _____ Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander Other _____ Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Chinese <input type="checkbox"/> Other	Insurance Name: _____ Policyholder: _____ Date of Birth: _____ SS#: _____ Address: _____ City/St/Zip: _____ Employer: _____ Relationship to Patient: _____ Effective Date of Coverage: _____ Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander Other _____ Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Chinese <input type="checkbox"/> Other

If any of the information above changes, please notify us in a timely manner. If patient is unable to sign and you are Healthcare Power of Attorney or Legal Guardian, you must provide us with legal documentation for our records. If applicable, please provide us with a copy of Advanced Directives as well.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____