

Today's Date ____ / ____ / ____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last First Middle			<input type="checkbox"/> Mr <input type="checkbox"/> Mrs	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
			<input type="checkbox"/> Miss <input type="checkbox"/> Ms	
Is this your legal name? <input type="checkbox"/> YES <input type="checkbox"/> NO	If not, what is your legal name?	Birthdate / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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: <input type="checkbox"/> 1 – Full-Time <input type="checkbox"/> 2 – Part-Time <input type="checkbox"/> 3 – Not Employed <input type="checkbox"/> 4 – Self-Employed <input type="checkbox"/> 5 – Retired <input type="checkbox"/> 6 – Active Military				
Student Status: <input type="checkbox"/> F – Full-Time Student <input type="checkbox"/> P – Part-Time Student <input type="checkbox"/> N – Not a Student				
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Declined				
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined				
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other _____				

Pharmacy:	Do you have a living will? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Referred By (Please check one box) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____

Other Family Members Seen Here
PCP Name Phone #

RESPONSIBLE PARTY INFORMATION

Responsible Party: <input type="checkbox"/> Another Patient <input type="checkbox"/> Guarantor <input type="checkbox"/> Self		<input type="checkbox"/> 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? <input type="checkbox"/> WORKERS COMPENSATION (WC) <input type="checkbox"/> OCCUPATIONAL MEDICINE (OM) <input type="checkbox"/> MOTOR VEHICLE ACCIDENT (MVA) <input type="checkbox"/> ACCIDENT DATE _____					
Does the patient have healthcare coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO			Insurance Name		
Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance		Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

EMERGENCY CONTACT

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