

Today's Date ____/____/____

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
Patient Name Last		First	Middle
		<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs
		<input type="checkbox"/> Miss	<input type="checkbox"/> Ms
Marital Status (circle) Single/ Married / Divorced /Sep/ Widow			
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 (To be used for appointment reminders)	
		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
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				(information used for patient balance statements)	
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 ()

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

Patient/ Guardian Signature

Date