



Patient Registration Form

Today's date:	PCP:	Referred By:
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PATIENT INFORMATION					
Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Social Security Number:			Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:		Cell Phone:		Home Phone:	
P.O. Box:		City:	State:	ZIP Code:	
Primary Language:		Email:			
Occupation:	Employer:	Employer address:		Employer phone:	
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Decline to State			Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American/Black <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Decline to State		

INSURANCE INFORMATION	
Primary Insurance (Carrier & ID #):	Secondary Insurance (Carrier & ID #):
Subscriber:	Subscriber's Birth Date: / /
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

RELEASE OF HEALTH INFORMATION		
Is okay to leave messages on your phone? <input type="checkbox"/> Home <input type="checkbox"/> Cell	Is okay to discuss your health information with another person? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who?

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ()	Work phone: ()

The above information is true to the best of my knowledge. I understand that it is my responsibility to notify the clinic of any changes to this information.

Patient/Guardian Signature _____
Date