



# Patient Registration Form

NAME (Last, Middle, First)		Social Security Number	Date of Birth
Address		City, State, Zip Code	
Home Phone	Daytime Phone	Cell Phone	Contact Number, Other
Marital Status	Student Status (FT/PT)	Smoker? (Y or N)	Email address
Primary Care Physician _____		<u>To comply with Government reporting please mark which applies</u>	
Referring Physician _____		<u>Race</u> <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> American Indian /Alaskan Native <input type="checkbox"/> Black/African <input type="checkbox"/> Hispanic <input type="checkbox"/> Hawaiian/ Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Refused to report <u>Primary Language spoken</u> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/> Refuse to report <u>Ethnicity</u> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Refuse to report	
How did you hear about our practice Who may we thank for the referral?		Friend or relative	Newspaper Ad   Insurance Company   Physician Referral   Billboard
<b>Primary Insurance Card MUST be provided at time of service or services will be provided as Self-Pay</b>			
Primary Insurance Name _____		Group Name _____	Group Number _____
Primary Insured Name _____		Insured ID# _____	
Address to send Claims _____			
Secondary Insurance Name _____		Group Name _____	Group Number _____
Primary Insured Name _____		Insured ID# _____	
Address to send Claims _____			

Primary Employer	Emergency Contact Name and Relation
Address	Emergency Contact Phone
City, State, Zip Code	Emergency Contact Address
Work Phone	

<b>Responsible Party Information – If different than self/patient</b>			
NAME (Last, First, Middle)		Social Security Number	Date of Birth
Address		City, State, Zip Code	
Home Phone	Daytime Phone	Cell Phone	Contact Number, Other
Marital Status	Student Status (FT/PT)	Relationship to Patient ( Parent, Spouse, child, etc.)	
Signature of Patient/Guardian _____			Date _____