PATIENT REGISTRATION

Today's Date: ___________

PATIENT: *(Please Print)*

Patient Name: ____
Last First Middle Initial

Address: ____
Apartment Number/ Street Address

City/State/Zip: ____

Mailing Address (if not above): ______________________________

Employer: ____

Sex: ☐Male ☐ Female

Date of Birth: ______________________________

Social Security Number: ______________________

Home Phone Number:( )____________________

Cell Phone Number:( )____________________

Email Address: ______________________________

Work Phone Number:( )____________________

Preferred Contact Number (circle): Cell Home Work

Preferred method of contact for appointment reminders (circle): Call Text Email

If you do not wish to provide your race and/or ethnicity, please select Decline.

Race: ☐White ☐African American/Black ☐Native Hawaiian/Pacific Islander ☐Hispanic ☐Native American ☐Other ☐Decline

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other ☐Decline

Preferred Language: ______________________________

Marital Status: ☐ Single ☐ Married ☐ Other Place of Birth: ____________________ Religion: ______________________________

Employment Status: ☐ Employed ☐ Full-time Student ☐ Part-time Student

Chosen Physician within this Practice: ____

Referral from: ☐ Relative ☐ Friend ☐ Yellow Pages ☐ Physician Finder ☐ Insurance Directory ☐ Employee

☐ Physician Name ______________________________

Emergency Contact: ____( )____________
Name Relationship Phone Number

Preferred Pharmacy: ____
Name Address

GUARANTOR

Person Responsible for Payment: Name (If not above): ______________________ ☐ Patient ☐ Spouse ☐ Parent/Guardian ☐ Other

Address (if not above): ______________________________ Social Security Number: ______________________

Phone Number (if not above): Home:( )____________________ Work:( )____________________

List those we can speak with regarding your health: ____

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____ ______________________

Signature of Patient or Legal Representative *(Parent/Guardian/Power of Attorney)* Date