Patient Registration Form

Today's Date [/ /] **Signature of Patient** ______________________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

Date of Birth [/ /] **Age** ________ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Name ____
Last First Middle Suffix

Address 1 ____

Address 2 ____

City________________________________ **State**__________ **Zip Code** ____________

Home Phone __________________________ **Cell Phone** __________________________

Email address____
By providing my email address, I authorize my doctor to contact me via the email address provided.

Preferred Pharmacy (store and location): ____

Social Security # [- -] **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer/School ____
Name Address Phone

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other__________ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Contact Preference: *(check one)* ❑ Home Phone ❑ Cell Phone

May we leave personal medical information on your:

Cell Phone voicemail? ☐ YES ☐NO Home Phone voicemail? ☐ YES ☐NO

Emergency Contact Information:

In case of Emergency, who should be notified?______________________ Phone (   )_______________

Relationship to patient: ____

Do you give our office permission to discuss your medical information with family members?

☐ YES ☐NO If yes, please provide their names and phone numbers below.

Name: _____________________________________ Relationship: ___________________________

Phone # (day): (______)________________ Phone # (evening): (_____)________________

Primary Care Physician ________________________ Preferred Pharmacy ______________________________

Parent, spouse, or responsible party *(if different from patient)*

Name: ____Date of Birth: ____/____/____
Last *First* *M.I.*

Address:____
City *State* *Zip*

Home Phone: (   )_______________________ Work Phone: (   )_______________________

Insurance coverage - PRIMARY:

Insurance Co. Name:_____________________ Name of Policy Holder (Insured):_________________________________

Policy Holder (Insured) Date of Birth: ____/____/____ Policy Type: ☐ HMO ☐ PPO

Policy #:_________________________________ Group Name or #:________________________________

If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐

Insurance Coverage - SECONDARY:

Insurance Co. Name:_____________________ Name of Policy Holder (Insured):_________________________________

Policy Holder (Insured) Date of Birth: ____/____/____ Policy Type: ☐ HMO ☐ PPO

Policy #:_________________________________ Group Name or #:________________________________

If patient is child, check relationship to insured: ☐☐Mother Other_☐ Father_____________

Please present your insurance card(s) and a photo ID
to the receptionist along with this completed form. Thank you.