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PATIENT REGISTRATION FORM

Legal Name: _____DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Preferred: ☐ Home ☐ Cell

E-mail: _____ SSN: _____-_____-_____

☐ Female ☐ Male Marital Status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Widowed

Ethnicity: ☐ Not Hispanic ☐ Hispanic ☐ Decline to State

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or Pacific Islander ☐ Other: _____ ☐ Decline to State

Employer: _____ Work Phone: (_____)_____

Referring Physician: _____

Primary Care Physician (if different from above): _____

Primary Insurance: _____ Effective Date: _____

Subscriber's Name (if different from patient): _____

Insured's DOB: _____ Relationship to Patient: _____

Secondary Insurance: _____ Effective Date: _____

Subscriber's Name (if different from patient): _____

Insured's DOB: _____ Relationship to Patient: _____

Please designate who our offices CAN disclose information to by selecting the boxes below:

☐ Spouse: _____ Phone (if different): _____

☐ Other: _____ Phone: _____

☐ Other: _____ Phone: _____

☐ Okay to leave health information on voicemail.

I agree that all above information is true and current to the best of my ability. If any changes in my insurance or address occur, I will notify the receptionist as soon as I am able.

_____ Date: _____

Signed by Patient