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| **PATIENT REGISTRATION FORM****\*\*Please complete in its entirety\*\*** |

**Patient Name:** (First, Middle Initial, Last)

Social Security Number: Birth Date (MM/DD/YYYY):
**Gender:** Male, Female, Female-to-Male, Male-to-Female, Genderqueer, other:\_\_\_\_\_\_\_\_\_\_\_
**Sex on birth certificate:** Male or Female  **Pronoun:** He/Him She/Her They/Them

Address: \_\_\_\_\_\_\_

 City State Zip

Work Phone: Home Phone: Cell Phone:

E-mail: **Marital Status:** Married Single Divorced Widowed

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone:

Employer Address:

 City State Zip

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race:**  American Indian/Alaska Native Asian Black/African American White

Native Hawaiian/Pacific Islander Other **Preferred Language Spoken** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity:** Hispanic or Latino Not Hispanic or Latino

**Minor Patient:** Patient resides with? Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:

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| **Guarantor** (For example “self” or give details of parent, guardian, or other person responsible for payment): |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date (MM/DD/YYYY):

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone:

Email address:

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| **Emergency Contact:** (A person we may contact if unable to reach patient and/or responsible party): |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt Phone:

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| **Insurance \*\*If Worker’s Comp, MVA or 3rd party liability, please see receptionist\*\*** |

**MUST PROVIDE COPY OF INSURANCE CARD(S)**

**Primary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder:

ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:

Policy Holder’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Birth Date:

**Secondary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If Applicable) Policy Holder:

ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:

Policy Holder’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Birth Date: