Patient Registration Form
Please complete in its entirety

Patient Full Name: _____

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

Full Address: _____
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 **Ethnicity:** Hispanic or Latino Not Hispanic or Latino

Preferred Language Spoken _____

Minor Patient: Patient resides with? Name: _____ Relationship: _____

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: _____

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

Name: _____ Relationship to Patient: _____

Phone: _____ Alt Phone: _____

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: _____