PATIENT REGISTRATION FORM

(Please print clearly)

Last Name: _____**First Name**: _____ **Middle Initial**: _____

Date of Birth: _____ **Gender:** Male/Female **Marital Status:** Single/Married/Divorced/Separated/Widowed

Primary Language: English/Spanish/Vietnamese/Portuguese/Other _____ **Race**: _____

Home Address: _____

Street ***City*** ***State*** ***Zip***

Email Address _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

MEDICAL INSURANCE INFORMATION

Name of Insurance _____

Member ID number _____ Group # _____

Name of Subscriber _____

Employer _____ Phone Number: _____

Relationship to Patient: Self □ Parent □ Spouse □ Partner □ Other

Address (if different from patient) _____

Street ***City*** ***State*** ***Zip***

SECONDARY INSURANCE INFORMATION

Name of Insurance _____

Member ID number _____ Group # _____

Name of Subscriber _____

Employer _____

Relationship to Patient: Self □ Parent □ Spouse □ Partner □ Other

Address (if different from patient) _____

Street ***City*** ***State*** ***Zip***

Responsible person: (if different from patient)

Last Name _____ MI _____ First Name _____

Date of Birth _____ Telephone # _____ **Relationship to patient**_____

Address_____

Street ***City*** ***State*** ***Zip***

EMERGENCY CONTACT

Last Name: _____ First Name: _____ Middle Initial: _____

Phone Number: _____ Cell Number: _____ Relationship to Patient: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Phone Number: _____ Cell Number: _____ Relationship to Patient: _____

Patient Signature: _____ ***Date:***_____

Parent/Responsible Persons Signature: _____ ***Date:***_____