

PATIENT REGISTRATION FORM



Today's Date ____ / ____ / ____

PATIENT INFORMATION

Patient Name Last	First	Middle	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	Marital Status (circle) Single/ Married/ Divorced /Sep/ Widow
			<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	

Is this your legal name? <input type="checkbox"/> YES <input type="checkbox"/> NO	If not, what is your legal name?	Birthdate / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> T
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Street or Mailing Address (circle one)	City	State	Zip Code	Home Phone Number ()
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Cell Phone Number ()	E-Mail Address	Social Security - -
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Occupation	Employer	Employer Phone Number
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Employment Status: 1 – Full-Time 2 – Part-Time 3 – Not Employed 4 – Self-Employed 5 – Retired 6 – Active Military
Student Status: F – Full-Time Student P – Part-Time Student N – Not a Student

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American
White Hispanic Other Declined
Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined
Language: English Spanish Indian Japanese Chinese Korean French German Russian
Other _____

Pharmacy:	City:	Do you have a living will? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Referred By (Please check one box)
 Dr. _____ Insurance Hospital Family Friend Yellow Pages Other _____

Other Family Members Seen Here

PCP Name	Phone #
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RESPONSIBLE PARTY INFORMATION

Responsible Party: Another Patient Guarantor Self Check here if information is same as patient

Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	()

Occupation	Employer	Employer Address	Employer Phone Number ()
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INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? WORKERS COMPENSATION (WC)
 OCCUPATIONAL MEDICINE (OM) MOTOR VEHICLE ACCIDENT (MVA) ACCIDENT DATE _____

Does the patient have healthcare coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	Insurance Name
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Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)
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Patient Relationship to Insured Self Spouse Child Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)
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Patient Relationship to Insured Self Spouse Child Other _____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ()	Other Phone Number ()
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I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient/ Guardian Signature

Date