

**Patient Registration Information**

**Patient Information**

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Other: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Gender: <input type="checkbox"/> Male	Race: <input type="checkbox"/> American Indian	Preferred Language: <input type="checkbox"/> English
<input type="checkbox"/> Female	<input type="checkbox"/> Asian	<input type="checkbox"/> French
	<input type="checkbox"/> Black	<input type="checkbox"/> German
Ethnicity: <input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Sign Language
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Spanish
<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Prefer not to answer

Primary Care Physician: \_\_\_\_\_

Emergency Contact: Name/Relationship: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Guarantor / Responsible Party (for patient under 18)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Guarantor Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Other: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Guarantors Employer: \_\_\_\_\_

**Primary Insurance Coverage  Card Provided**

Insurance Company: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

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

Insured D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Secondary Insurance Coverage  Card Provided**

Insurance Company: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

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

Insured D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Please notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about the patients health status, treatment, or the informed decision making process, such as; foreign language, hearing or speech impairment, difficulty with reading or writing or inability to comprehend verbal instruction.

**Verification of Information:** I verify that the above information provided is true and correct to the best of my knowledge. I verify that I have been provided services or information regarding a resolution of barriers to effective communication or educational instruction as indicated.

X \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of patient /guardian/accompanying adult