

PATIENT REGISTRATION FORM

Today's Date ____ / ____ / ____

PATIENT INFORMATION					
Patient Name Last		First	Middle	Birthdate / /	
				Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> T
Is this your legal name? <input type="checkbox"/> YES <input type="checkbox"/> NO		If not, what is your legal name?		Home Phone Number ()	SS#
Street or Mailing Address (circle one)			City	State	Zip Code
					Cell Phone Number ()
E-Mail Address		Child lives With:			
Siblings (Name and Date of Birth):					
Student Status: <input type="checkbox"/> F – Full-Time Student <input type="checkbox"/> P – Part-Time Student <input type="checkbox"/> N – Not a Student					
School Attended:					
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Declined					
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined					
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other _____					
Pharmacy:			Do you have a living will? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Referred By (Please check one box) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____					
Other Family Members Seen Here					
PCP Name			Phone #		
PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION					
Responsible Party:					
Name		Address		Home Phone Number	
Birth Date / /		E-Mail Address		()	
Occupation	Employer	Employer Address		Employer Phone Number ()	
Second Parent/Guardian Information:		Name		Address	
				Home Phone Number	
Birth Date / /		E-Mail Address		()	
Occupation	Employer	Employer Address		Employer Phone Number ()	
INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)					
Is this visit for one of the following? <input type="checkbox"/> WORKERS COMPENSATION (WC) <input type="checkbox"/> OCCUPATIONAL MEDICINE (OM) <input type="checkbox"/> MOTOR VEHICLE ACCIDENT (MVA) <input type="checkbox"/> ACCIDENT DATE _____					
Does the patient have healthcare coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO			Insurance Name		
Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance		Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
EMERGENCY CONTACT					
Name (Last, First)		Relationship to Patient	Home Phone Number ()	Other Phone Number ()	

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