Patient Registration Form

Patient Information

Name: ______________________ Preferred first name: ______________________

DOB: ______________________ ❑ Female ❑ Male SSN: ______________________

Primary phone: ______________________ Type: ❑ Home ❑ Cell ❑ Work Marital status: ______________________

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American

❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Primary language: ______________________

Primary address: ______________________

City: ______________________ State: ______________________ Zip: ______________________

Secondary address: ______________________

City: ______________________ State: ______________________ Zip: ______________________

Alternative phone: ______________________ Type: ❑ Home ❑ Cell ❑ Work

Employment Information

Employment status: ______________________ Employer: ______________________

Employer address: ______________________

City: ______________________ State: ______________________ Zip: ______________________

Phone: ______________________ Ext: ______________________

Personal email*: ______________________ Preferred method of notification: ❑ Phone ❑ Email

**Personal email is required for access to the patient portal*

Additional Patient Information

Primary care physician: ______________________

Person financially responsible: ______________________ Relationship: ______________________

Emergency contact: ______________________ Emergency contact: ______________________

Relationship to contact: ______________________ Relationship to contact: ______________________

Contact phone: ______________________ Contact phone: ______________________

Referring physician (if different from primary care): ______________________

How did you hear about us? ______________________

Patient Registration Form

Insurance Information

Primary: ________________________ Secondary: ________________________

Policy holder ID: ________________________ Policy holder ID: ________________________

Policy holder name: ________________________ Policy holder name: ________________________

Policy holder DOB: ________________________ Policy holder DOB: ________________________

Patient relationship to policy holder: ____________ Patient relationship to policy holder: ____________

Policy holder sex: ❑ Female ❑ Male Policy holder sex: ❑ Female ❑ Male

Co-pay amount: ________________________

Pharmacy: ________________________ Location: ________________________

Pharmacy phone: ________________________

Extended Information

Do you have a visual impairment that will prevent you from reading written material from your doctor? ❑ Yes ❑ No

Do you have a hearing impairment that will complicate spoken communication with your doctor? ❑ Yes ❑ No

Have you seen a specialist since your last visit with your primary care doctor? ❑ Yes ❑ No

If yes, please indicate the name of the provider(s) below.

Provider: ________________________

Provider: ________________________

Patient signature: ________________________ Date: ____/____/____

Printed name: ________________________