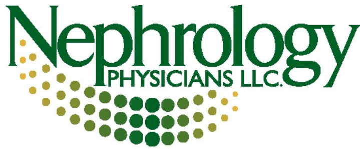

Patient Registration Form

Please print and complete in full

Date ___________________

Patient Information

Last Name _____________________________________ First Name ______________________________MI ______

Address ____

City ____ State __________ Zip Code ____________________

Home Phone _________________________________ Work Phone ____

Cell Phone ___________________________________ E-Mail ____

Social Security Number __________________________________ Date of Birth ______________________________

Sex: M F (circle one) Marital Status: S M D W (circle one)

Patient Employer Information

Current Status: Employed Retired Disabled Student Other (circle one)

Employer's Name ____

Health Care Contact Information

Primary Care Physician ____ Phone ____________________________

Home Health or Visiting Nurse ___________________________________ Phone ____________________________

Nursing Home Name ____ Phone ____________________________

Other Providers: ____ Phone ____________________________

____ Phone ____________________________

Emergency Contacts

Name	Relationship	Phone Number

Patient Registration Form Continued

Please print and complete in full

May we leave messages on your answering machine/voice mail? Yes No (circle one)

May we leave messages with members of your household? Yes No (circle one)

I give consent for the practice to speak with the following individuals about any aspect of my medical treatment:

____

____

What is your race? (circle one) American Indian or Alaska Native Asian Black or African American Native Hawaiian or other Pacific Islander White Other Race Decline to answer

What is your ethnicity? (circle one) Hispanic or Latino Not Hispanic or Latino Decline to Answer

What is your primary language? (fill in blank) ____

Who is your Power of Attorney? ______________________________Phone____________________________

(Please bring a copy of this paperwork to your appointment)

Who is your Surrogate Decision Maker? ___________________________Phone________________________

Insurance Information

Primary Insurance Name ____

Identification Number ____

Group/Policy Number ____

Address ____City __________________________________

State _________ Zip Code _____________ Phone Number ____

Secondary Insurance Name ____

Identification Number ____

Group/Policy Number ____

Address ____ City ___________________________________

State _________ Zip Code _____________ Phone Number ____

Policy Holder Information (If other than patient)

Last Name ______________________________ First Name ____________________________MI ______

Address ____

City ____ State ________ Zip Code ________________

____ ____________________

Patient or Responsible Party Signature Date