PATIENT REGISTRATION INFORMATION

Patient Name: Last _____ First _____ MI ____

Date of Birth: _____ / _____ / _____ Social Security #: _____ - ____ - _____ Email: _____@_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

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

Gender: [ ] Male [ ] Female

Race: [ ] Black [ ] Hispanic [ ] White [ ] Other: _____

Language: [ ] English [ ] Spanish [ ] Sign Language [ ] Other: _____

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino

Please notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about the patient's 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.

Primary Care Physician: _____ Phone Number: (_____) _____ - _____

Emergency Contact: _____ Phone Number: (_____) _____-_____
Relationship:

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: (_____) _____ - _____

Guarantor Employer: Phone:

Primary Insurance Coverage

Insurance Company: _____ Name of Insured: _____

Relationship to Patient: _____ Insured D.O.B.: _____ / _____ / _____

Insured Social Security **#:** _____ - _____ - _____

Secondary Insurance Coverage

Insurance Company: _____ Name of Insured: _____

Relationship to Patient: _____ Insured D.O.B.: _____ / _____ / _____

Insured Social Security **#:** _____ - _____ - _____

Verification of Information: I verify that the above information provided is true and correct to the best of my knowledge.

X _____ Date: _____ / _____/_____

Signature of patient /guardian/accompanying adult