PATIENT REGISTRATION FORM

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient Name Last First Middle		Birthdate / /	Age Sex □ M □ F □ T
Is this your legal name? □ YES □ 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: □F – Full-Time Student □P – Part-Time Student □N – Not a Student **School Attended**:			
Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined **Ethnicity:** □Hispanic or Latino □Not Hispanic or Latino □Declined **Language:** □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other _____			
Pharmacy:		Do you have a living will? □ YES □ NO	
Referred By (Please check one box) □ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ 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? □ WORKERS COMPENSATION (WC)
□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE _____

Does the patient have healthcare coverage? □ YES □ NO			Insurance Name		
Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____					
Name of Secondary Insurance	Name of Insured		Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured □ Self □ Spouse □ Child □ 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