PATIENT REGISTRATION – PLEASE PRINT

PATIENT_____ AGE_____ BIRTHDATE_____/_____/_____

ADDRESS_____CITY_____STATE_____ ZIP_____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

SOCIAL SECURITY NO._____ DRIVER'S LICENSE NO._____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ OTHER LANGUAGE SPOKEN_____

RACE: ☐ NATIVE HAWAIIAN ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ ALASKA NATIVE
☐ AMERICAN INDIAN ☐ OTHER PACIFIC ISLANDER ☐ DECLINE TO ANSWER QUESTION

ETHNICITY: ARE YOU HISPANIC OR LATINO? ☐YES ☐ NO ☐ DECLINE TO ANSWER QUESTION

LIST ALLERGIES: ☐ _____ ☐ NONE

PHARMACY:_____ PHONE NUMBER:_____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP TO PATIENT_____

ADDRESS_____CITY_____STATE_____ ZIP_____

HOME PHONE: _____ CELL PHONE: _____ OTHER PHONE: _____

EMPLOYER'S INFORMATION:

NAME OF EMPLOYER: _____ WORK PHONE:_____

ADDRESS_____CITY_____STATE_____ ZIP_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____ SECONDARY:_____

ADDRESS:_____ ADDRESS:_____

CITY:_____STATE:_____ZIP:_____ CITY:_____STATE:_____ZIP:_____

CARDHOLDER:_____ CARDHOLDER:_____

GROUP NUMBER:_____ GROUP NUMBER: _____

ID NUMBER:_____ ID NUMBER:_____

PHYSICIAN'S ASSIGNED BENEFIT

I HEREBY AUTHORIZE MY PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS. I ASSIGN ANY BENEFITS PAYABLE BY MY INSURANCE CARRIER TO MY PHYSICIAN FOR SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE COMPANY.

_____ _____

SIGNATURE OF INSURED OR AUTHORIZED PERSON DATE REGISTERED