PATIENT REGISTRATION

INFORMATION ENTERED OR VERIFIED BY___________________

DATE____ SOCIAL SECURITY #____

FIRST NAME___________________________________ MIDDLE___________________ LAST NAME____

HOME ADDRESS____

CITY____ STATE____ ZIP______________________________

SEX________________ DATE OF BIRTH_______________________ **LANGUAGE SPOKEN** ____

EMAIL____ ☐ CHECK IF NONE ☐ CHECK IF REFUSED

HOME PHONE (________) __________________________WORK (________) __________________________CELL (________) ___________________________

PREFERRED PHARMACY_______________________________________**LOCATION OR PHONE**____

MARITAL STATUS SINGLE MARRIED DIVORCED DOMESTIC PARTNERSHIP WIDOWED

RACE (CHECK ONE) ASIAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER BLACK OR AFRICAN AMERICAN
WHITE HISPANIC OTHER RACE DECLINE TO REPORT

ETHNICITY (CHECK ONE) HISPANIC OR LATINO NOT HISPANIC OR LATINO DECLINE TO REPORT

(CHECK ONE) EMPLOYED RETIRED FULL TIME STUDENT DISABLED OTHER_________________________________

EMPLOYER____

EMPLOYER ADDRESS____CITY___________________________ STATE________ ZIP____________________

EMERGENCY CONTACT

RELATIONSHIP____

FIRST NAME______________________________________MIDDLE___________________ LAST NAME____

HOME PHONE (________) _________________CELL PHONE (________) _________________WORK PHONE (________) ___________________________________

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

ONLY COMPLETE INSURANCE INFORMATION IF YOU **DID NOT** HAND YOUR CARD TO RECEPTIONIST

INSURANCE COMPANY_______________________________________ POLICY #____________________________GROUP # ______________________________

MEDICAL CLAIMS MAILING ADDRESS ____

CUSTOMER SERVICE PHONE (________)___________________________ INSURED / CARD HOLDER'S NAME_____________________________________

RELATIONSHIP____ PHONE (________)____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY #____ SEX____________ DATE OF BIRTH___________________________________

RELATIONSHIP____ DAYTIME PHONE (________)______________________________________

FIRST NAME_____________________________MIDDLE_____________ EMPLOYER____

LAST NAME____ ADDRESS____

ADDRESS____ CITY_______________________STATE_____________ZIP______________________

CITY_______________________STATE__________ZIP______________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to Release any information acquired in the course of my treatment necessary to process Insurance claims.

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SIGNATURE (Patient or Parent if Minor) **DATE**