PATIENT REGISTRATION FORM

(Please fill in every blank, including back of form)

Today's Date_____

PATIENT NAME: _____

*****IF MINOR PARENT'S NAME_____

ADDRESS: _____

_____

HOME PHONE: (___)_____ **CELL PHONE**: (___)_____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

SEX □ MALE □ FEMALE

E-MAIL ADDRESS: _____

RACE
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Caucasian
□ Native Hawaiian
□ Other Pacific Islander
□ Other _____

ETHNICITY
□ Hispanic or Latino
□ Not Hispanic or Latino

PREFERRED LANGUAGE
□ English
□ Spanish
□ Other: _____

PREFERRED METHOD TO CONTACT YOU
□ Home Phone okay to leave message
□ Home Phone NOT okay to leave message
□ Cell Phone okay to leave message
□ Cell Phone NOT okay to leave message
□ Work Phone

EMPLOYMENT STATUS
□ Employed
□ Unemployed
□ Self-employed
□ Retired
□ Disabled

OCCUPATION: _____ **WORK PHONE**: (___)_____

EMPLOYER'S NAME AND ADDRESS: _____

_____

MARITAL STATUS
□ SINGLE □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED

NAME OF SPOUSE: _____

EMERGENCY CONTACT (Someone not living with you)

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Do you have an advance medical directive? (Living will and/or durable power of attorney for healthcare)? YES or NO

RESPONSIBLE PARTY (Required for all minors)

Name: _____ Date of Birth: _____

Address: _____

Relationship: _____ Social Security #: _____

Home Phone ( )_____ Cell Phone ( )_____

PRIMARY INSURANCE INFORMATION

Insurance Carrier: _____ Policy #: _____

Subscriber Name:_____ Date of Birth: _____

Social Security #: _____ Relationship: _____

SECONDARY INSURANCE INFORMATION

Insurance Carrier: _____ Policy #: _____

Subscriber Name:_____ Date of Birth: _____

Social Security #: _____ Relationship: _____

RELEASE OF INFORMATION

Due to HIPAA regulations we are **NOT** able to release any information about you to anyone, including your family, without your written permission. This means that we **CANNOT** give your spouse your test results or appointment information.

Do you want anyone to be allowed to receive information for you: please circle answer below:

NO YES, please list names below

_____
_____
_____
_____
_____
_____
_____

By signing below, I am verifying that all the information on this form is truthful and accurate to the best of my knowledge.

X_____ _____

Patient signature DATE

Patient/Legal Guardian