Patient Registration Information

Patient Demographics - Please complete the following information regarding the patient being seen today.

Patient Name:	Address:
Date of Birth:	City, ST:
SSN:	Zip: Country:
Male Female Marital Status: M S W D	Home: Cell:
Language : English / Spanish / Other:	Email:
Hispanic Origin: Yes / No Race:	Employer:
Relation to Guarantor: Self / Other:	Address:
Guarantor:	City, ST:
Patient AKA: Note: *Please list all names used in the past or present*	Zip: Country:
How did you hear about us?	Work Phone:
What is your preferred language for discussing health care?	Retirement Date:

Subscriber Information/Responsible Party - Please complete the following information regarding the person financially responsible.

Name: Relationship to Patient: Same as Patient? ☐		Employer:	
Address:		Address:	
City, ST:		City, ST:	
Zip:	Country:	Zip:	Country:
Home:	Cell:	Work:	
SSN:	DOB:	☐ Male	☐ Female

Emergency Contacts - Please complete the following information regarding the person(s) to contact in case of an emergency.

Contact: Relationship:		Contact: Relationship:	
Home: Work:	Cell:	Home: Work:	Cell:

Insurance Information - Please complete the following information regarding the insurance(s) that you wish to use today.

Did you injure yourself on the job? ☐ check here

Insurance -1:		Insurance -2:	
Policy /ID No.:	Group No.:	Policy /ID No.:	Group No.:
Subscriber Name: Relation to Patient: Self / Other:		Subscriber Name: Relation to Patient: Self / Other:	

Please provide a picture ID and any insurance cards to the Registration Staff when you return this form. Thank you.