PATIENT REGISTRATION FORM

***=Required Field for EMR**

PATIENT INFORMATION

*Last Name: ___________________________________ *First Name: __________________________M.I.____ Pronoun: __________

Former Name: _________________*Gender Identity: ________________*Birth Sex: _________*Date of Birth:_________________

*Mailing Address:____

Street Address (if different than mailing):____

*City:____*State:_________________________*Zip code:_________________

Home Phone #: ________________________Mobile/Cell Phone #: ________________________Work Phone: ___________________

*Preferred Phone Contact: **HOME** **MOBILE/CELL** **WORK** ***(circle)***

May we leave a message with appointment information **YES___NO___** Medical information **YES___NO___?** ***(circle)***

*Email Address:____

*Race(s)____________________________________ Ethnicity: Hispanic/Latino Not Hispanic/Latino Refused Unknown ***(circle)***

*Marital Status: _______________________ Primary Language________________________Religion____________________________

Primary Care Provider _______________________________Referring Provider (if not primary care doctor) ______________________

Preferred Pharmacy: ______________________________________ Location: ____

EMPLOYER INFORMATION

*Employment Status: Full time Part time Not employed Disabled Retired Student Self Employed ***(circle)***

*Retirement/Disability Date (if applicable): _______________________

Employer:____Occupation:_______________________________________

Address:____

State:_______________________________Zip: ____________________________Phone:____

GUARANTOR/ CONTACT INFORMATION

Guarantor Name:____DOB:___________________Phone #:__________________________

Relationship to Patient: _____________________________________

*Emergency Contact: _____________________________________ DOB: __________________ *Phone:___________________________

*Relationship to Patient: __________________________________

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INSURANCE INFORMATION

***Primary Insurance:**____

*Primary Insured Name:_____________________________ *DOB:__________________

*Relationship to Patient:______________________ *Policy #:_______________________

Group #:__________________________ Effective Date:____________ Expiration Date:__________

Secondary Insurance:____

Secondary Insured Name:____________________________ DOB:__________________

Relationship to Patient:______________________ Policy #:_______________________

Group #:__________________________ Effective Date:____________ ExpirationDate:__________

***Is this Worker's Comp./Motor Vehicle Accident or Other Liability Claim?** ________ If Yes, date of injury__________

Claim #________________________ Contact Name/Case Worker:______________________

Liability Insurance Name:______________________ Phone #_________________________

Address:____

I certify that the above information is correct to the best of my knowledge:

***SIGNATURE:** ________________________________ **DATE:**____________________

***Name (Print):** ________________________________ **Relationship to patient:**____________