Patient Registration Form

DATE:			
PATIENTS LAST NAME:	FIRST:	MIDDLE:	
SOCIAL SECURITY NUMBER:	BIRTHDATE:	SEX: ☐ M ☐ F	
HOME ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME PHONE NUMBER: ( )	WORK PHONE NUMBER: ( )	CELL PHONE NUMBER: ( )	
EMAIL:	EMPLOYER:		
EMERGENCY CONTACT:	EMERGENCY CONTACT RELATIONSHIP:		
EMERGENCY CONTACT PHONE NUMBER: ( )			
RACE: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Decline to Specify			
PRIMARY LANGUAGE SPOKEN:			
ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify			
MARITAL STATUS: ☐ Single ☐ Widow ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner			
INSURANCE INFORMATION – Please Present Cards to Receptionist			
PATIENT COVERED BY INSURANCE: ☐ YES ☐ NO			
NAME OF PRIMARY INSURANCE:			
POLICY HOLDERS NAME:	POLICY HOLDERS' SOCIAL SECURITY NUMBER:	POLICY HOLDERS BIRTH DATE: / /	
PATIENTS RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Child ☐ Other			

SECONDARY INSURANCE INFORMATION		
NAME OF SECONDARY INSURANCE:		
POLICY HOLDERS NAME:	POLICY HOLDER SOCIAL SECURITY NUMBER:	POLICY HOLDERS BIRTH DATE: / /
PATIENTS RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Child ☐ Other		

MEDICARE POLICY HOLDERS
1.) Do you or your spouse work for a company that provides you with health insurance? ☐Yes ☐No
If retired, please indicate the date in which you retired:

HOW DID YOU HEAR ABOUT US?
☐ Friend ☐ Physician ☐ Newspaper ☐ Driving by ☐ Internet ☐ Family ☐ Brochure ☐ YMCA ☐ Other:

I hereby verify that this information is accurate.

Signature_____ Date_____