PATIENT REGISTRATION INFORMATION

Patient Name: Last_____ **First**_____ **MI** _____

Date of Birth:____/____/____ **Social Security #:**____-___-____ **Email:**_____@____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (____**)**____-____ **Cell Phone: (**____**)**____-____ **Other: (**____**)**____- ____

Gender: [ ] Male [ ] Female [ ] Other Please Specify:_____

Language: [ ] English [ ] Spanish [ ] Sign Language [ ] Other: _____

Race: [ ] Black [ ] Hispanic [ ] White [ ] Other: _____

Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino

Please notify the staff of a disability that may require special needs or of a barrier to communication or educational instruction that would prevent the understanding of information about the patient's health status, treatment, or the informed decision making process, such as; foreign language, hearing or speech impairment, difficulty with reading or writing or inability to comprehend verbal instruction. Assistive services within our capability will be provided to you free of charge.

Emergency Contact:_____ **Phone: (**____**)**____-____

Relationship: _____

Guarantor / Responsible Party for minor

[ ] Check box if address and phone number is the same as the patient's information.

Last Name:_____ **First Name:**_____ **MI:**_____
Relationship to patient: _____
Date of Birth:____/____/____ **Guarantor Social Security #:**____-__-____ **Mailing Address:** _____
City:_____ **State:**_____ **Zip:** _____
Home Phone: (**)**____- **Cell Phone: (** **)**____-____ **Other: (** **)** _ - ____
Guarantor Employer:_____ **Phone: (** **)**____- _____

Primary Insurance Coverage

Insurance Company:_____ **Name of Insured:** _____
Relationship to Patient:_____ **Insured D.O.B.:**____/____/____
Insured Social Security #:____-____- _____

Secondary Insurance Coverage

Insurance Company:_____ **Name of Insured:** _____
Relationship to Patient:_____ **Insured D.O.B.:**____/____/____
Insured Social Security #:____-____- _____

I verify that the above information provided is true and correct to the best of my knowledge. I understand that the company will require me to update this information at least annually and as necessary when changes occur in my status.

X_____ Date:____/____/____

Signature of Patient /Guardian/Accompanying Adult