## Patient Registration Form

How did you hear about us?

## **Patient Information** Name: \_\_\_\_\_\_ Preferred first name: \_\_\_\_\_ DOB:\_\_\_\_\_\_ Female Male SSN:\_\_\_\_\_ Ethnicity: Hispanic or Latino Not Hispanic or Latino Race: American Indian or Alaska Native Asian Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Primary language: Primary address: \_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_ Secondary address: City:\_\_\_\_\_\_State:\_\_\_\_\_Zip:\_\_\_\_\_ Alternative phone: Type: Type: Under Cell Work **Employment Information** Employment status: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer address: City:\_\_\_\_\_State:\_\_\_\_\_Zip:\_\_\_\_\_ Phone: Ext: Preferred method of notification: $\square$ Phone $\square$ Email Personal email\*: \*Personal email is required for access to the patient portal **Additional Patient Information** Primary care physician: Emergency contact: Emergency contact: Relationship to contact: \_\_\_\_\_\_ Relationship to contact: \_\_\_\_\_ Referring physician (if different from primary care):



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Printed name: \_

misurance information	
Primary:	Secondary:
Policy holder ID:	Policy holder ID:
Policy holder name:	Policy holder name:
Policy holder DOB:	Policy holder DOB:
Patient relationship to policy holder:	Patient relationship to policy holder:
Policy holder sex: ☐ Female ☐ Male	Policy holder sex: ☐ Female ☐ Male
Co-pay amount:	
Pharmacy:	Location:
Pharmacy phone:	
<b>Extended Information</b> Do you have a visual impairment that will prevent you from reading written material from your doctor? □ Yes □ No	
Do you have a hearing impairment that will complicate spoken communication with your doctor?  Yes  No	
Have you seen a specialist since your last visit with your primary care doctor? ☐ Yes ☐ No	
If yes, please indicate the name of the provider(s) below.	
Provider:	
Provider:	
Patient signature:	Date:/

