Patient Registration

(Please Print)

INT-4535 rev11/16

PATIENT INFORMATION

Please present your insurance card at each visit.

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City, State) (Zip Code)

(Phone Number) (Cell Phone Number)

(E-mail Address) (Date of Birth)

(Sex) (Marital Status) (Social Security Number)

(Employer Name)

(Employer Address)

(Employer City, State) (Zip Code)

(Employer Phone Number)

(Primary Physician)

(Emergency Contact Name)

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black, African American ☐ Native Hawaiian, Other Pacific Islander ☐ White ☐ Unknown ☐ Declined

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown ☐ Declined

LANGUAGE: ☐ English ☐ Spanish ☐ French ☐ German ☐ Chinese ☐ Other_____

(Patient's Occupation)

(Emergency Phone Number) (Relationship to Patient)

GUARANTOR INFORMATION (If guarantor is the same as patient, omit this section.)

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City, State) (Zip Code)

(Phone Number) (Marital Status)

(Social Security Number) (Date of Birth)

(Employer Name)

(Employer Address)

(Employer City, State) (Zip Code)

(Employer Phone Number)

(Cell Phone Number)

INSURANCE INFORMATION (SUBSCRIBER)

PRIMARY INSURANCE _____

Address _____ City/State _____ Zip _____

Who holds insurance _____ Birthdate _____

Relationship to Patient _____ Policy # _____ Group # _____

Employer _____ SS# _____ Work Phone _____

SECONDARY INSURANCE _____

Address _____ City/State _____ Zip _____

Who holds insurance _____ Birthdate _____

Relationship to Patient _____ Policy # _____ Group # _____

Employer _____ SS# _____ Work Phone _____

HOW WERE YOU REFERRED TO US?

(Please check how you were referred to our clinic.)

☐ Insurance ☐ Radio ☐ Print Ad (newspaper, magazine)
☐ Family/Friend ☐ TV ☐ Physician_____
☐ Billboard ☐ Internet ☐ Other_____

ADVANCED DIRECTIVE / LIVING

Would you like information regarding Advanced Directives?

☐ Yes ☐ No

Please be advised that we will initiate CPR and dial 911 when a patient is in distress.

Signature _____ **Date** _____

What is the best phone number to contact you? _____