REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:		
Address:		
City:	**State:**	**Zip Code:**
Home Phone:		
Mobile Phone:	**Other Phone:**	
Patient e-mail:		
Date of Birth:	**Sex:** ☐ **Male** ☐ **Female**	
Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Unknown**		
Race: ☐ **Black/African American** ☐ **Asian** ☐ **White** ☐ **American Indian/Alaskan Native** ☐ **Native Hawaiian/Other Pacific Islander** ☐ **Unknown**		
Ethnicity: ☐ **Hispanic** ☐ **Non-Hispanic**		
Primary Language: ☐ **English** ☐ **Spanish** ☐ **Other:** _____		
Social Security Number:		
Primary Care Doctor:		

EMPLOYER INFORMATION

Employment Status: ☐ **Employed** ☐ **Self-employed** ☐ **Retired** ☐ **Disabled** ☐ **Student** ☐ **Unemployed**
Employer Name:
Employer Telephone:

EMERGENCY CONTACT

Emergency Contact Name:
Relationship to Patient:
Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Parent/Guardian Name:		
Address:		
City:	**State:**	**Zip code:**
Telephone:		

INSURANCE INFORMATION

Insurance Company:	
Policy / Group Number:	**Effective Date – From:**
Subscriber Name:	**Patient's Relationship to Insured:**
Subscriber SSN:	**Subscriber's DOB:**
Subscriber Employer:	**Subscriber's Sex:** ☐ **Male** ☐ **Female**