Patient Registration Information

Patient Demographics - Please complete the following information regarding the patient being seen today.

Patient Name:	Address:
Date of Birth:	City, ST:
SSN:	Zip: Country:
Male Female Marital Status: M S W D	Home: Cell:
Language : English / Spanish / Other:	Email:
Hispanic Origin: Yes / No Race:	Employer:
Relation to Guarantor: Self / Other:	Address:
Guarantor:	City, ST:
Patient AKA: Note: *Please list all names used in the past or present*	Zip: Country:
How did you hear about us?	Work Phone:
What is your preferred language for discussing health care?	Retirement Date:

Subscriber Information/Responsible Party - Please complete the following information regarding the person financially responsible.

Name: Relationship to Patient: Same as Patient? ☐	Employer:
Address:	Address:
City, ST:	City, ST:
Zip: Country:	Zip: Country:
Home: Cell:	Work:
SSN: DOB:	☐ Male ☐ Female

Emergency Contacts - Please complete the following information regarding the person(s) to contact in case of an emergency.

Contact: Relationship:	Contact: Relationship:
Home: Cell: Work:	Home: Cell: Work:

Insurance Information - Please complete the following information regarding the insurance(s) that you wish to use today.

Did you injure yourself on the job? ☐ check here

Insurance -1:	Insurance -2:
Policy /ID No.: Group No.:	Policy /ID No.: Group No.:
Subscriber Name: Relation to Patient: Self / Other:	Subscriber Name: Relation to Patient: Self / Other:

Please provide a picture ID and any insurance cards to the Registration Staff when you return this form. Thank you.