

Patient Registration Form		
Last Name:	First Name:	Previous Name (if applicable)
Facility:	Address:	
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Preferred method of contact for reminder calls and other electronically generated messages: (Please select only one option) <input type="checkbox"/> Voice <input type="checkbox"/> Text		If Voice, please select preferred number : <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Date of Birth:	<input type="radio"/> Male <input type="radio"/> Female	Family Physician or Pediatrician:
Marital Status:	Social Security #:	
Emergency Contact Name:	Emergency Contact Phone #:	
Alternative Contact Name and Phone Number:		Relationship to Patient:
PERSON RESPONSIBLE FOR THE BILL <input type="radio"/> Self <input type="radio"/> Other (IF OTHER PLEASE FILL OUT COMPLETELY)		
Last Name:		First Name:
Date of Birth:	Phone:	Relationship to Patient:
ADDITIONAL INFORMATION (please fill out all sections below)		
Email Address:	Can we leave a message regarding your medical care & test results? <input type="radio"/> Yes <input type="radio"/> No	
PREFERRED PHARMACY: Name and location:		
RACE (please select): <input type="radio"/> White <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Hispanic <input type="radio"/> Black or African American <input type="radio"/> Native Hawaiian or Pacific Islander <input type="radio"/> Other <input type="radio"/> Decline		ETHNICITY (please select one): <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Decline
PREFERRED LANGUAGE (please check one): <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other		
Primary Medical Insurance		Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name	
Policy Holder Name:	Policy Holder Name:	
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:	
Policy Holder's Social Security #:	Policy Holder's Social Security #:	
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:	
ID Number:	ID Number:	
Group Number:	Group Number:	
<input type="checkbox"/> Primary Care <input type="checkbox"/> Urgent Care <input type="checkbox"/> Transitions <input type="checkbox"/> Face to Face <input type="checkbox"/> Physician Support		