

**PATIENT REGISTRATION**

**PATIENT INFORMATION:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ A.K.A. \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (H)#: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_

Email: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

**Race (circle):** Asian Native Hawaiian Other Pacific Islander White More than one race Black/African American Decline

**Ethnicity (circle):** Hispanic/Latino Non-Hispanic/Non-Latino Decline

**Preferred Language (circle):** English Spanish German Other/Not Listed

Is it O.K. if we take a photograph of you to keep in your chart/send to your referring physician? YES \_\_\_\_\_ NO \_\_\_\_\_

If we call in a prescription for you, what pharmacy do you use?

Pharmacy Name: \_\_\_\_\_ City: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (H)#: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_

**MESSAGE INFORMATION:**

Is it O.K. to leave an answering machine/voice mail message for you to: (Please circle "Y" or "N".)

Remind you of an appointment?	Y	N	Leave lab or nasal smear results?	Y	N
Tell you a medication has been refilled?	Y	N	Discussion of financial issues?	Y	N
Reply to medical questions:	Y	N			

If you are unavailable, is there anyone whom we can speak with regarding the above questions:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION: (Subscriber/Policyholder/Person whom policy is under) \_\_\_\_\_ ( "✓" If same as patient.)**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone (H)#: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_

Place of Employment: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION: (Subscriber/Policyholder/Person whom policy is under)**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone (H)#: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_

Place of Employment: \_\_\_\_\_

By my signature below I acknowledge I have received the Notice of Privacy Practices and have been given an opportunity to review it

**Signature of Patient, Parent, or Legal Guardian:** \_\_\_\_\_