Patient Registration Form

Patient Name:____

(Last) ____

SS#: ________________ Date of Birth: ____/____/____ Age: ________________

Mailing Address: ____

(City) ____

(State) ____

Home Phone: (   )________________ Work Phone: (   ) ________________

Cell Phone: (   )________________ Do you receive text messages? ❍ YES ❍ NO

Preferred method of communication for appointment reminders?

❍ Email ❍ Cell phone call ❍ Cell phone text ❍ Home phone call

Email Address: ____

May we contact you via Email? ❍ YES ❍ NO

Primary Care Physician____

Whom can we thank for referring you here? ________________________________

Primary Spoken Language: ____________________________________

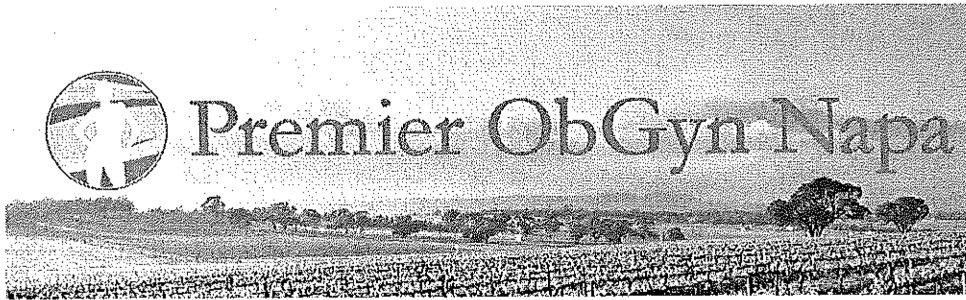
Race: ____________________ Ethnicity: ________________________

Marital Status: ❍Single ❍Married ❍Widowed ❍Divorced ❍Separated ❍Partnered

Do you work outside the home? ❍ YES ❍ NO

Employers Name and Address: ____________________________________

____



Emergency Contact Info

Contact Name: ____

Relation to Patient: ____

Address: ____

Phone number: (   ) ________

○ Cell ○ Work ○ Home ○ Other: ____________

Responsible Party:

○ Same as above; I am the responsible party

IF there is someone else responsible for your medical care/insurance/payments, please fill in THEIR information below:

Parent/Guardian/Other – Name: ____

Date of Birth: ___/___/___ ____

Phone number: (   ) __________

Address: ____

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