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