Patient Registration

Last Name: ________________________ First Name: ____________________DOB: _____/ ______/_______

Gender: Male _____ Female ______ Language Preference: ___________________________

Name of parent or Legal Guardian (For Minors): ____

Address : ____City: __________________ Zip: ___________

Are you currently homeless: ☐ Yes ☐ No Preferred Method Message: ◻ Text ◻ Voice

Email Address: ____ Cell Phone: _________________________

Home Phone: __________________________________ Preferred Number: Cell or Home

Emergency Contact Name: __________________________________ Relationship: ________________

Emergency Contact Phone: __________________________________

Please circle one in each category:

Marital Status: Single / Married / Divorced / Widowed / Legally Separated

Do you consider yourself: Hispanic or Latino / Not Hispanic or Latino

What is your race? (Mark all that apply) American Indian or Alaska Native / Asian / Native Hawaiian / Black or African American / White / Pacific Islander

Student Status: Full Time / Part Time / Not a Student

Employment Status: Full-time / Part-time / Not employed / Retired / Self-employed / Active Military

Employer Name: _______________________________________

Occupation: ______________________________

Employer Phone # _____________________________________

Do you currently have Medicaid or Medicare? ◻ Yes ◻ No

Medicare or Medicaid Number: ___________________________________

Please have your card available for your registration appointment.

Family Information - anyone applying and anyone living with the applicant who has legal responsibility for the applicants is counted as part of the household and his/her income is included in the household's income. A spouse is legally responsible for his/her spouse, and parents are legally responsible for their minor children. If separated or divorced you must present legal documentation. (If a parent/legal guardian wishes to consent for another individual to bring their minor child to be seen they must sign the "Consent for Treatment of Minor without Parent Form" to grant temporary permission.)

Total Estimated Income: ______________________ □ Monthly □ Annual

Household Size: _______________________

Name	Relationship	Date of Birth

For Office Use Only:

□ Consent for Treatment Form (Signed by patient or patient's guardian)

□ Financial Policy

□ HIPAA Notice of Privacy

□ Non Continuous Coverage

□ All information entered into Patient Account by: _________________________________ (print staff name)

Form Received by / verified by: ____ (print staff name)