REGISTRATION INFORMATION

PLEASE PRINT

NEW HEALTHCARE MANDATES REQUIRE ALL PATIENT REGRISTRATION INFORMATION FIELDS TO BE COMPLETED:

Date: _____

PARENTS INFORMATION

Father: _____
(Last Name) (First Name) (Initial)
Home Address: _____
_____
Home Phone: _____ Cell: _____
Employed by: _____
Business Address: _____
Occupation: _____ Phone: _____
Social Security# _____ Date of Birth: _____

Mother:_____
(Last Name) (First Name) (Initial)
Home Address: _____
_____
Home Phone: _____ Cell: _____
Employed by: _____
Business Address: _____
Occupation: _____ Phone: _____
Social Security# _____ Date of Birth: _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for this account?: _____
Address: _____
_____
Phone: _____

DEPENDENT INFORMATION

Patient: _____
(Last Name) (First Name) (Initial)
Date of Birth: _____ Male _____ Female _____

RACE:
( )White
( )Black/African America
( )American Indian/Alaska Native
( )Asian
( )Native Hawaiian/Pacific Islander
( )All Other Races
( )Patient Declined to Specify/Unknown

ETHNICITY:
( )Hispanic/Latino
( )Not Hispanic/Latino
( )Declined to Specify/Unknown
( )None

PRIMARY LANGUAGE:

COUNTRY:

Additional children in the practice:

Patient: _____
(Last Name) (First Name) (Initial)
Date of Birth: _____ Male _____ Female _____

RACE:
( )White
( )Black/African America
( )American Indian/Alaska Native
( )Asian
( )Native Hawaiian/Pacific Islander
( )All Other Races
( )Patient Declined to Specify/Unknown

ETHNICITY:
( )Hispanic/Latino
( )Not Hispanic/Latino
( )Declined to Specify/Unknown
( )None

PRIMARY LANGUAGE:

COUNTRY:

Patient: _____
(Last Name) (First Name) (Initial)
Date of Birth: _____ Male _____ Female _____

RACE:
( )White
( )Black/African America
( )American Indian/Alaska Native
( )Asian
( )Native Hawaiian/Pacific Islander
( )All Other Races
( )Patient Declined to Specify/Unknown

ETHNICITY:
( )Hispanic/Latino
( )Not Hispanic/Latino
( )Declined to Specify/Unknown
( )None

PRIMARY LANGUAGE:

COUNTRY:

What primary pharmacy do you use?: _____
Second pharmacy choice?: _____
Do you have an email address: _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Policy Holder Name: _____

Secondary Insurance Name: _____
Policy Holder Name: _____

Please present insurance card to receptionist, you will be asked to present your card at each visit.

PRIVACY INFORMATION

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

May we leave appointment messages on/with:		leave other medical information on/with:	
Your answering machine?	__Yes __No	Your answering machine?	__Yes __No
Mobile Phone?	__Yes __No	Mobile Phone?	__Yes __No
Mobile Text?	__Yes __No	Mobile Text?	__Yes __No
Office Voice Mail?	__Yes __No	Office Voice Mail?	__Yes __No
With another person?	__Yes __No	With another person?	__Yes __No
Through the mail?	__Yes __No	Through the mail?	__Yes __No
Via Email?	__Yes __No	Via Email?	__Yes __No

If you answered **YES** to allowing us to discuss your appointment and/or medical information with another person, please list the name(s) and relationship(s) with whom we may discuss this information below:

_____

_____

_____

_____