

# PATIENT REGISTRATION

Date \_\_\_\_\_

SS/HIC/Patient ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_  
Street City State Zip

E-mail \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ Minor

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Ext \_\_\_\_\_

Best Time and Place to Reach You \_\_\_\_\_

Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_

### **Marital Status:**

Married  Widowed  Single  Separated  Divorced  Partnered for \_\_\_\_\_ years

### **Select one of the following Race/Ethnic Groups:**

Hispanic  Black  White  American Indian/Alaska Native  Asian/Pacific Islander

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone ( ) \_\_\_\_\_

### **Spouse's Information**

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Social Security # \_\_\_\_\_

### **Minor Information**

Guardian/Custodial Parent Name \_\_\_\_\_

Guardian/Custodial Parent Address \_\_\_\_\_  
Street City State Zip

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Ext \_\_\_\_\_

Employer \_\_\_\_\_ Social Security # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### **IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ Ext \_\_\_\_\_