PATIENT REGISTRATION INFORMATION

(Please Print and Complete All Entries)

PATIENT

PATIENT NAME (LAST, FIRST, MIDDLE)

MAIDEN NAME/ALIAS:

SOCIAL SECURITY NUMBER:

DATE OF BIRTH:

AGE:

SEX: ☐ MALE ☐ FEMALE

ETHNICITY: ☐ HISPANIC ☐ NOT HISPANIC

RACE: ☐ CAUCASIAN ☐ HISPANIC ☐ NATIVE AMERICAN ☐ AFRICAN AMERICAN ☐ ASIAN ☐ OTHER_____

IHS PRIMARY TRIBE: _____

HOUSEHOLD ADDRESS:

CITY, STATE:

ZIP CODE:

TELEPHONE (PRIMARY):

CELL PHONE:

PATIENT'S EMAIL:

PREFERRED LANGUAGE:

PRIMARY CARE PHYSICIAN:

PRIMARY CARE PHYSICIAN'S TELEPHONE:

EMPLOYMENT STATUS: ☐ FULL ☐ PART ☐ RETIRED ☐ NOT EMPLOYED

EMPLOYER:

EMPLOYER ADDRESS:

INTERPRETER NEEDED: ☐ YES ☐ NO

MARTIAL STATUS: ☐ N/A ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

GUARANTOR

GUARANTOR:

RELATIONSHIP TO PATIENT:

SOCIAL SECURITY NUMBER:

DATE OF BIRTH:

AGE:

SEX: ☐ MALE ☐ FEMALE

ADDRESS:

CITY, STATE:

ZIP CODE:

EMPLOYER:

OCCUPATION:

EMAIL:

CELL PHONE:

EMERGENCY CONTACT

NAME: _____

RELATIONSHIP:_____

LEGAL GUARDIAN: ☐ YES ☐ NO

HOME PHONE:_____ ☐ PRIMARY

WORK PHONE: _____ ☐ PRIMARY

CELL PHONE: _____ ☐ PRIMARY

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive medical information about the above referenced patient that includes appointment and medication reminders and billing information as consistent with State and Federal Law. I understand that anyone I do not list here will not be allowed to access any of my medical information without a valid authorization unless compelled by State or Federal Law. I also understand that I am not obligated to authorize anyone to receive medical information in this field if I so choose. This authorization is valid for one (1) year.

PRIMARY CONTACT

NAME:

RELATIONSHIP TO PATIENT:

TELEPHONE (PRIMARY):

TELEPHONE (SECONDARY):

SECONDARY CONTACT

NAME:

RELATIONSHIP TO PATIENT:

TELEPHONE (PRIMARY):

TELEPHONE (SECONDARY):

PRIMARY INSURANCE

INSURED NAME:

INSURANCE COMPANY NAME:

BILLING ADDRESS:

CITY, STATE:

ZIP CODE:

TELEPHONE:

EFFECTIVE DATE:

INSURED SOCIAL SECURITY NUMBER:

INSURED DATE OF BIRTH:

GROUP NUMBER:

POLICY NUMBER:

SECONDARY INSURANCE

INSURED NAME:

INSURANCE COMPANY NAME:

BILLING ADDRESS:

CITY, STATE:

ZIP CODE:

TELEPHONE:

EFFECTIVE DATE:

INSURED SOCIAL SECURITY NUMBER:

INSURED DATE OF BIRTH:

GROUP NUMBER:

POLICY NUMBER:

I certify that all the information above is true and correct and agree to inform the clinic as soon as possible if any of this information changes.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

PATIENT ACCOUNT # (STAFF SECTION)

DATE