Patient Registration Sheet

Last Name	First Name	MI	AKA (Also known As)	Birth Date	Today's Date
Address	City State, Zip Code				MRN/ACCT #
Home Phone	Work Phone	Cell Phone	Sex	Marital Status	Social Security #
Email Address:					
Employer Name:	Employer: Address:				
Emergency Contact /Other Parent Name (Relationship):					
Emergency Contact Phone # - Home:	Work:	Cell:			

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

Last Name	First Name	MI	Relationship to Patient	
Address	City		State	Zip Code
Home Phone	Work Phone	Social Security #	Birth Date	Gender

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Name		Insurance Name	
Claims Address		Claims Address	
Subscribers Name	Group No.	Subscribers Name	Group No.
Subscribers ID	Subscribers Birth Date	Subscribers ID	Subscribers Birth Date
Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐		Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	

Work Comp / Other INSURANCE

Insurance Name	Subscribers Name	Subscribers ID
Claims Address	Group No.	Subscribers Birth Date

Race –White ☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Ethnic Classification – Non-Hispanic or Latino
☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined ☐ Unknown

Language - English or Please Print Preferred Language:

I,_____verify the above is accurate. Date:_____
(Signature of Patient/Guardian)