PATIENT REGISTRATION

Patient name ______________________

Street address ______________________ Today's date ______________

City, state, zip ______________________ Date of birth ______________ Age ______

Home phone ______________________ Sex Male

Work phone ______________________ Female

Cell phone ______________________ Marital status Single

Email address ______________________ Married

How often do you check email? ______________________ Divorced

Social security # ______________________ Widowed

Language 1 ______________________ Race ______________

Language 1 ______________________ Ethnicity ______________

Pharmacy name ______________________ Phone ______________

Address ______________________

Primary physician ______________________ Phone ______________

Address ______________________

Referring physician ______________________ Phone ______________

Address ______________________

Relative or friend we can call if we are unable to contact you:

Name ______________________ Phone ______________

Relationship ______________________

Person who has power of attorney for your health matters, if any:

Name ______________________ Phone ______________

Health insurance in patient's name

Plan ______________________

ID number ______________________

Plan ______________________

ID number ______________________

HRA/HSA Yes No

Account number ______________________

Health insurance in other's name

Plan ______________________

ID number ______________________

Subscriber name ______________________

Subscriber date of birth ______________________

Relationship to patient ______________________

Patient's (or Subscriber's) employment

Employed? Yes No Retired

Date retired ______________________

Occupation ______________________

Employer ______________________

Total number of employees, if known ______________

Work address ______________________

City, State, Zip ______________________

Work phone ______________________

Spouse's employment

Employed? Yes No Retired

Date retired ______________________

Occupation ______________________

Employer ______________________

Total number of employees, if known ______________

Work address ______________________

City, State, Zip ______________________

Work phone ______________________

If your present condition is the result of an injury:

Date of injury ______________________

Workmen's Compensation contact name

____

Insurance co. ______________________

Attorney name ______________________

Accident-related? Yes No

Work-related? Yes No

Personal injury? Yes No

Contact phone ______________________

Insurance phone ______________________

Attorney phone ______________________